

Women's Health and Nutrition



*Socioeconomic,
Cultural and Legal Factors
Affecting Girls'
and Women's Health*

George T. F. Acsádi
Gwendolyn Johnson-Acsádi
1993

This report is one of a series of working papers prepared for the
World Bank's Women's Health and Nutrition Work Program



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**SOCIO-ECONOMIC, CULTURAL, AND LEGAL FACTORS
AFFECTING GIRLS' AND WOMEN'S HEALTH AND THEIR
ACCESS TO AND UTILIZATION OF HEALTH AND
NUTRITION SERVICES IN DEVELOPING COUNTRIES**

by

George T. F. Acsádi and Gwendolyn Johnson-Acsádi

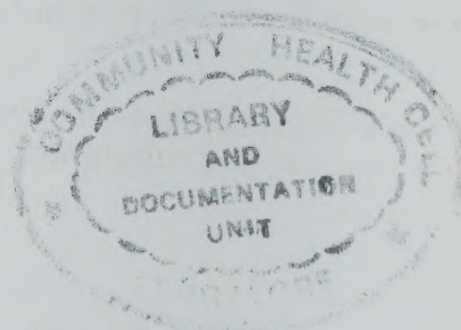
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INTRODUCTION

0.1 Human behavior is learned, shaped by those social prescriptions and controls that constitute culture. Tradition, mores, religion and the legal and political systems are the trappings of culture, and human behavior is not free of their influence. Culture determines sources of authority and power and defines status. It is the reference for judicature and specifies who and what each member is and how others will react to and deal with her or him. It enhances or retards political stability, economic growth and, importantly, recognition of and respect for individuals' human rights. Every aspect of the systematic maltreatment of women and girls has a cultural reference, is part of an institutionalized phenomenon. Consequently, amelioration of female gender determined sufferings and disadvantages will require alteration or banishment of elements of long established cultural patterns. In what follows, an attempt is made to identify the aspects of culture and the economic and social factors that affect women's and girls' health negatively and the conditions that are made worse by gender discrimination. The extreme paucity of relevant gender specific data restricted the selection and content of material. Governments and international organizations concerned with the condition of women could do much to enhance knowledge by gathering and publishing gender specific statistics and other information on all social, economic and health phenomena.

**I. FACTORS AFFECTING THE HEALTH OF FEMALE INFANTS
AND GIRLS**

**A. MORTALITY AS INDICATOR OF GENDER DIFFERENCES
IN HEALTH IN INFANCY AND EARLY CHILDHOOD**

1.1 The biological norm is that male fetuses are generally less viable than female fetuses and that newborn boys' are more susceptible to illness and death than girls. This inequality between the sexes seems to be compensated by the fact that more males are conceived than females. In statistically developed countries, the sex ratio at birth has been historically varied between 105-106 live born boys per 100 live born girls. In 1989, for example, Europe recorded a sex ratio at birth of 106 boys per 100 girls. Among infants who died, the sex ratio was much higher, 130 boys per 100 girls. The girls advantage remained, but was less pronounced among children who died at ages 1-4 years, 126 boys per 100 girls (United Nations, 1992b). Other developed regions reported similar ratios.

1.2 While the sex ratio at birth is genetically determined, after birth, such external factors as the physical, socio-economic, cultural and behavioral environments, including gender differentiated child care and the socially assigned roles of the sexes, gradually become dominant over the influence of innate genetic factors (Bourgeois-Pichat, 1952). As the European example shows, the genetic factors play a dominant role in sex-specific perinatal mortality when, around the time of birth, more infant boys than girls succumb to birth traumas, congenital anomalies and other conditions originating in the perinatal period. Due to the frailty of newborn boys, there is

still a considerable difference in the mortality of boys and girls not only during infancy but also in early childhood. In 1989, the number of girls who died in infancy was only three-fourths as large as of the number of boys (77.0 girls per 100 boys), and the girls' advantage was still significant at ages 1-4, when the inverse sex ratio among child deaths was 79.5 girls per 100 boys (United Nations, 1992b). Thus, it can be expected that in world regions or countries, where adequate nutritional and health conditions prevail and equal care is given to boys and girls, the girls under 5 mortality rate should be lower than that of the boys.

1.3 Table 1 gives estimated "under 5 mortality rates," which show "the probability of a newborn baby dying before reaching age 5" (World Bank, 1991, p. 287). The ratios of girls' to boys' under 5 mortality rates expressed as percentages indicate that, in the more developed regions, the genetical factors are dominant (i.e. the ratio is 75). However, in the less developed regions, where the ratio is 95, that is, the mortality of girls and boys is nearly equal, other than genetic factors, notably differential child care or neglect determine the ratio. This is supported further by the findings for 28 developing countries participating in the World Fertility Survey, which showed that, at ages 2-5, mortality was higher among girls in 18 of the countries, but at ages 1-2, in only 13 of them (UNFPA, 1989).

1.4 The measures calculated for the major world regions are averages of very different country ratios. In South America, for example, the ratio is only 74 for Argentina but 92 for Ecuador; the latter showing that the influence of other than genetic factors caused girls' mortality to be almost as high as that of boys. In Southern Asia, the ratio of 77 for Sri Lanka reflects the fact that there, girls' mortality is determined mainly by genetical factors, while the ratio of 114

Table 1: Female (F) and male (M) under 5 mortality rates and their ratio (F/M) in major world regions, 1989

Regions	F	M	F/M	Regions	F	M	F/M
World total	83	88	94	North America	11	13	85
Developed	15	20	75	Asia	86	86	100
Developing	94	99	95	Eastern	29	39	74
Africa	146	164	89	South-east	62	76	82
Eastern	161	180	89	Southern	136	124	110
Middle	155	171	91	Western	83	93	89
Northern	105	120	88	Europe	12	16	75
Southern	87	103	85	Eastern	17	23	74
Western	162	181	90	Northern	9	11	82
Latin America	44	54	82	Southern	15	18	83
Caribbean	66	75	88	Western	8	11	73
Central	48	59	81	Oceania	26	33	79
South	59	72	82	USSR (former)	25	33	76

Note: Computed as means of sex-specific under 5 mortality rates (deaths at ages 0-4 per 1000 live births) estimated for countries with population of over one million (see countries in Table 2) and published in World Bank, 1991; weighted by the number of 0-4 year old children in 1990 estimated by United Nations, 1991b.

for India indicates that socio-economic, cultural and behavioral phenomena raise the mortality of the girl child so high that it markedly exceeds that of the boys. Since the ratio of female to male under 5 mortality rates indicates whether the mortality of the sexes corresponds to genetical norms or is influenced by other factors, it can be used as a proxy to indicate gender differences in health in early childhood.

Table 2: Countries in developing regions by level of female under 5 mortality rate and the ratio of female to male under 5 mortality rates (F/M %), 1989

F/M %	Female under 5 mortality rate (per 1000 live girl born)				
	< 25	25-79	80-149	150-199	> 200
70-81	Mauritius	Argentina	--	--	--
	Jamaica	Botswana			
	Malaysia	Paraguay			
	Kuwait	China			
	Korea Rep.	Oman			
	Panama	Venezuela			
	Israel	Philippines			
	UA Emirat.	Viet Nam			
	Thailand	Tunisia			
	Korea Dem.	Colombia			
	Trinidad	Mexico			
	Chile				
	Sri Lanka				
	Uruguay				
	Hong Kong				
	Singapore				
82-87	Cuba	Nicaragua	Indonesia	Liberia	--
	Costa Rica	Brazil	Myanmar		
		Zimbabwe	Libyan A.J.		
		El Salvador	Morocco		
		Guatemala	S. Africa		
		Papua N. G.	Peru		
		Syrian A.R.	Iran		
		Honduras	Burundi		
		Mongolia	Kenya		
		Saudi Arabia	Namibia		
			Egypt		
			Zambia	Uganda	Mali
			Cameroon	Gabon	Somalia
88-100	--	Dominican R.	Lesotho	UR Tanzania	Angola
		Jordan	Ghana	Central AR	Chad
		Ecuador	Senegal	Sudan	Guinea
		Turkey	Togo	Benin	Niger
			Haiti	Nigeria	S. Leone
			Zaire	Lao PDR	Malawi
			Côte d'Ivoire	Ethiopia	
			Bolivia	Madagascar	
			Iraq	Mozambique	
			Algeria	Rwanda	
				Mauritania	
				Yemen	
				Burkina Faso	
				Bhutan	
				Nepal	
> 100	--	--	Pakistan		
			India		
			Bangladesh		--

Note: Only countries in less developed regions with population of over one million are included. Source: World Bank, 1991.

1.5 In several countries the ratio of girls' to boys' under 5 mortality is in the range of 70-81 indicating that, even if there were male preference in some of these countries it does not necessarily follow that the health of the girl child is generally neglected (see Table 2). Indeed, in many of these countries female under five mortality is low, less than 25 per 1000 births. In 11 other countries with somewhat higher female under five mortality rates (25-75), the F/M ratios remained in the 70-81 range, showing no undue influence of differential gender-specific behavioral factors. In countries where under five mortality is high, mainly due to preferential treatment of boys or, in worse cases widespread neglect of girls' health needs, the mortality of the girl child approaches that of the boys, and in five countries in South Asia, even surpasses it.

B. GENDER PREFERENCE: ITS ROOTS AND ITS ROLE AS DETERMINANT OF FEMALE HEALTH

1.6 The manifestations of gender bias vary markedly among the developing countries and are more severe in some than in others. From birth onward, there are gender specific inequities, whether subtle or unvarnished, veiled or open, condoned or censured by society that are to the detriment of females. In developing regions, gender discrimination among young children has its genesis in the preference for sons which is, in turn, deeply rooted in religion and culture. Son preference is both a cause and an effect of the low status of women. The supporting rationalizations for it generally fall into three broad categories: the role of sons in the performance of religious ritual; sons as economic support in old age; and sons as bearers of lineage.

1.7 In much of Asia and Sub-Saharan Africa, sons perform religious rituals, placate spirits of dead ancestors and are, ostensibly, responsible for the care of aged parents and widowed mothers. And in all developing regions, except for a few matriarchal societies such as found among some groups in South India, only sons can assure continuation of the lineage. In many Central and South American cultures, sons legitimate a man's claim to virility and, throughout the developing regions, they enhance their mother's status (United Nations, 1986; Ravindran, 1986; Acsadi and Johnson-Acsadi, 1990; Acsadi, *et al.*, 1991; UNICEF, 1990). Thus, where the preference for sons is strongest, the cultural justifications may persist even when the bases for these rationalizations weaken. For example, sons are still preferred in Bangladesh, because they are considered to be dependable in parents' old age, even though widowed mothers with sons may be found destitute (Merchant and Kurz, in press). And although girls are needed for certain rituals and to care for parents in their old age, boys may still be preferred, as among Nepalese Hindus (Karki, 1988). According to results of the World Fertility Survey in 38 countries, son preference is strongest in East and South Asia, North Africa and Middle Eastern countries, and absent or moderate in much of Sub-Saharan Africa, Southeast Asia, and Latin America, except Mexico and the Dominican Republic. Girls were preferred in Haiti, Jamaica, Philippines and Venezuela¹ (United Nations, 1987).

1.8 Manifestations of son preference in the consequent predicament of young girls vary in kind and intensity among and within countries, among cultures and over time. Where son preference is strongest, the maltreatment of girls is usually pervasive; it is the root cause of the

disproportionate female mortality and morbidity. The discrimination begins at birth and last until death, rising and falling in intensity (see UNICEF, 1990).

C. ATTITUDES TOWARD GIRLS, THEIR VALUE

1.9 It has been suggested that, in patriarchal societies, perceptions of a girl's worth reflect her value to and relationship with her parents. In the cultures of South Asia where a dowry or bride wealth must be paid to the groom's family, the tendency is to marry off girls as early as possible and to minimize the family's investment in her. Hence, the adage in Bangladesh that having a daughter is like "watering the neighbor's tree" (Visaria, 1988; Ravindran, 1986). Ceremonies and rituals accompany the birth of a South Asian boy, but rarely that of a girl. An Arab man is said to be insulted if referred to as the father of a daughter and, in Taiwan and other Chinese cultures, girls are considered to be as "water spilled on the ground" (Ravindran, 1986).

1.10 In some countries and in many ethnic groups of Sub-Saharan Africa, the bride price is a common and legally recognized requirement of marriage, and girls are valued for that and other reasons, including assistance to their mothers. When the girl brings wealth as bride price or dowry, as in some cultures of Africa and the Middle East, the family will often invest more in her, including schooling to enhance her marriage prospects (Seetharam *et al.*, 1976; Ravindran, 1986).

1.11 It should be noted, however, that a girl's value depends upon many things. Religion, caste, ethnic group, status within caste or tribe and social position of the family

influence her value and her lot in life (Krishnaraj, 1989; UNICEF, 1990). She has little worth in some Muslim societies, eg. Pakistan and Bangladesh, but is valued in others (for example, Indonesia), where she nonetheless experiences some discrimination (UNICEF and Indonesia, 1989). For the most part, girls are not wanted in South Asian countries. The extreme evidence is in the 8,000 feticides performed in Bombay following amniocentesis that, in all but one case, revealed a female fetus (UNICEF, 1990). A study in Punjab revealed that, of 450 female fetuses, 430 were aborted, while none of 250 male fetuses were removed (Visaria, 1988).

D. BEHAVIORAL MANIFESTATIONS OF NEGATIVE ATTITUDES AND CONSEQUENCES FOR GIRL'S HEALTH

BEHAVIORAL MANIFESTATIONS

1.12 Discrimination against girls is often a corollary of son preference, and it persists in varying degrees in most developing regions. It is most severe as practiced in South Asian countries. The evidence is persuasive that, where the incidence of mortality and morbidity is greater among girls than among boys, it is closely associated with and attributable to discrimination and neglect (UNICEF, 1990, 1991, World Bank, 1991). The forms that this discrimination takes have the capacity directly or indirectly to impair health and, often, to threaten life. Foremost among them are inequities in the allocation of food and food supplements, and in schooling and work responsibilities. Further, depending on the culture and circumstances, girls are subjected to violence and physical abuse, including circumcision, burns, beatings and injuries that result in reported "suicides" (United Nations, 1986). Many South Asian girls are liable to experience some or all of these. In addition, many girls in Southern and Western Asia, parts of North and Sub-Saharan Africa, and Latin America are forced into arranged early

marriage where they are prematurely exposed to coitus and childbearing with the attendant health problems.

1. Gender Discrimination in the Allotment of Food and Food Supplements

1.13 Some studies suggest that gender differences in feeding begin with infants. Among 8 countries that participated in the World Fertility Survey (WFS), boys were breastfed longer in Panama, Bangladesh and Jordan; girls barely longer in Sri Lanka and Indonesia, and there was equal treatment in Colombia, Guyana and Peru (Jain and Bongaarts, 1981). Visaria (1988), Royston and Armstrong (1989) and Ravindran (1986) reported that, in Haryana state and Uttar Pradesh, India, boys were breastfed longer than girls. In the latter, effort was made deliberately to give boys a better start in life. In squatter settlements of Amman, Jordan, girls were said to be weaned earlier (Waldron, 1987; Tekçe and Shorter, 1984). As with results of the WFS, the DHS, i.e. Demographic and Health Surveys did not confirm consistent discrimination against girls in the duration of breastfeeding (Arnold, 1991); in many DHS countries (Morocco, Tunisia, Thailand and Sri Lanka, 6 of 11 in Sub-Saharan African, and 6 of 9 Latin American countries) girls were breastfed longer. However, national samples such as these may often fail to identify regional conditions that are readily apparent from small area studies.

1.14 **a. Allocation of food and food supplements.** Neglect of girls in the allocation of food and food supplements is more universal among these countries than is unequal treatment in breastfeeding. It is common in South Asia, excluding Sri Lanka and the Maldives, that boys are given more food and more nutritious food than girls (Acsadi and Johnson-Acsadi, 1990).

Accordingly, sex bias is such that, in Khanna, India during 1984-85 male children under age 5 years received 22 percent more food than did girls (Das Gupta, 1987). In Matlab thana, Bangladesh in 1987, the daily calorie intake of boys below age 5 was 809 compared to 694 for girls of corresponding age, and the boys' and girls' daily protein consumption was 23.0 and 20.3 grams, respectively (Chen, *et al.*, 1989). Ravindran (1986) noted a similar inequity in Tlaxacala, Mexico and in Laguana, Philippines. In the latter, girls are said to be preferred to boys but, among 97 households, male children had better diets than their sisters. Examples of such inequity may be found in every developing region. Waldron (1987) states that girls are fed less adequately than boys in Algeria, at ages 2 to 23 months also in Guatemala, and are more nutritionally deprived in Egypt. From age six months onward, Indonesian boys are said to be substantially better fed and nourished (UNICEF and Indonesia, 1989).

1.15 **b. Nutrition.** There is considerable evidence that, in tandem with the gender differences in food allocation, girls experience malnutrition and growth problems more often than boys. Such differences in the nutritional status of children have been observed to be substantial in Syria, the Iribid district of Jordan (Ravindran, 1986) and throughout South Asia (Ruzicka and Kane, 1986; Ravindran, 1986; Khan, *et al.*, 1989; Visaria, 1988). Substantially greater percentages of boys than of girls had protein energy malnutrition in Calendria, Colombia, among the Bedouin in Saudi Arabia, in Mahabad, Iran, among poor neighborhoods in Kingston, Jamaica (Ravindran, 1986) and among pre-school children in Philippines and Tunisia (Xenos, 1984; 1984a). And girls are found to be nutritionally disadvantaged relative to boys in Sierra Leone (UNICEF and Sierra Leone, 1989) and Sri Lanka (UNICEF and Sri Lanka, 1991). Gender

differences in nutrition derived from anthropometric data have also been detected among children in communities of Bolivia, Mexico, Pakistan, Iran and Jordan (Merchant and Kurz, in press), although after an examination of data from four Guatemalan villages, Pebley (1984) found a lack of it among children aged 0-7. It appears, therefore, that there are in most, if not all cultures that regulate behavior in developing regions some traditions, attitudes or values which, when effectuated, result in wider prevalence of malnutrition among girls than among boys.

2. Access to Health Care

1.16 Where there is gender discrimination in the allocation of food and food supplements, girls also tend to experience discrimination in respect to other aspects of parenting. In many cultures, they are less likely to receive medical care than boys and, where care is given, it is more likely to be a home remedy or traditional medicine, whereas boys are more likely to be given allopathic treatment by a physician or in a clinic or hospital. Examples of this form of gender discrimination throughout South Asia have been widely reported (Das Gupta, 1987; Visaria, 1988; Acsadi and Johnson-Acsadi, 1990; Nag, 1991; Khan, *et al.*, 1989; Bhatia, 1983). Visaria wrote of conditions in India: "... the differential treatment [allopathic care for boys] reflects the fact that the parents are willing to forgo several days of wages and incur heavy cost to save a male child but not for a daughter" (Visaria, 1988, p. 12). Khan and colleagues (1989) confirmed this, adding that the local doctors reported that girls were neglected and not given treatment in time, while Basu (1989, p. 207) related that, parents "panic at the appearance of an infection in a son".

1.17 The neglect of girls' health is not confined to South Asia. When immunization was provided for children without cost in a Korean community health project, there were no gender differences in immunization. But when a small fee was introduced, the proportion of girls receiving the care dropped to little more than 25 percent (Ware, 1984). Among small children hospitalized in Lomé, Togo and Serabu, Sierra Leone, only 40 percent were girls (United Nations Office at Vienna and CEPED, 1992), and it was found probable that, in Lagos, Nigeria more boys than girls would be brought to the primary health care center (Ravindran, 1986). This phenomenon is repeated in the Middle East (United Nations, 1986), in Jordan, Algeria and Syria (Waldron, 1987), and in Bab El Sharenja, Egypt (Ravindran, 1986). Information on gender specific health care for Latin American children is scarce. However Waldron (1987) reported evidence of male favored bias in Guatemala.

3. Socio-Economic Status and Gender Differences in Health Care

1.18 The education of women is considered by many to be a panacea for a wide variety of social, economic and health problems. It is well documented that the better educated women are more attentive to their children's health needs and more competent at child care. What is surprising and of importance to health policy makers is that the margin in good health care that boys enjoy over girls is greater where mothers are better educated than where they have had little or no schooling. This is true with respect to choice of health care provider and/or utilization of health care facilities in Bangladesh (Chen, *et al.*, 1989), India (Visaria, 1988) and Jordan (Tekçe and Shorter, 1984). Basu (1989) noted this pattern in Uttar Pradesh, India and found, in addition, that mothers with lower status (defined as caste or income) were much fairer in

providing medical treatment for their sons and daughters. Writing of nutritional deficiencies among children in South Asia, Ruzicka and Kane (1986) stated that the margin of discrimination in favor of boys was greater among the landed than the landless. Tekçe and Shorter (1984) reported that, not only was increased mothers' education associated with shorter periods of breastfeeding in squatter settlements around Amman, Jordan, but that the more educated women shortened the breastfeeding of girls significantly more than that of boys. Xenos (1984, 1984a) reported to the FAO that, in the Philippines (where there is a preference for girls) and in Tunisia, increased education of mothers reduced child malnutrition in general, but not the boys' advantage.

1.19 If the better educated women are more likely and more willing than their less schooled, often illiterate counterparts to make such distinctions among their children as result in the comparatively greater health impairment of daughters than sons, what hope is there for the betterment of the conditions in which so many little girls exist? Complicating any explanation is the fact that this seeming anomaly occurs in such disparate social and religious settings. Furthermore, poverty and ignorance can not be accepted as the sole explanations for these expressions of gender bias: not only mothers' better education, in some places, higher economic status also worsened the girls' health status relative to that of boys. This is telling evidence of the great strength and tenacity of the cultural tenet that boys are to be favored and of the pervasive societal acceptance of the supporting mechanisms.

4. Education

1.20 Lack of education circumscribes girls' entire life. It cements their low status in society, ensures that they will be ignorant of their rights, guarantees their low self-esteem, and causes them to accept the disadvantageous conditions that, in many countries, society deems their lot. Ignorant and illiterate, they cannot determine nor aptly deal with their health needs nor those of their children. And, in time, they pass along to their children values that ensure the perpetuation of the situation. Such is the legacy of millions of girls in Asia and Africa. Primary school enrolment of Latin American and Caribbean girls, however, is on par with that of boys (United Nations Office at Vienna, 1989) and, in secondary schools exceeds that of boys. In 1987, there were 73 Asian girls for every 100 boys enrolled in primary school, 77 in the Arab states and 80 in Sub-Saharan Africa (UNFPA, 1992). The secondary school enrolment gender gap in favor of boys is widest in South Asia, Sub-Saharan Africa, North Africa, and Western Asia in that order, and greater in Central and West Africa than in the Eastern and Southern regions (United Nations, 1991). The low enrolment of girls and their high rate of drop-outs compared to boys are partly due to parents' decision to invest in sons rather than daughters and to the persistent custom of marrying girls off when they are very young. Early marriage is incompatible with education. Later marriage does not ensure the schooling of girls, but it is congruous with school attendance and is, in fact, a prerequisite.

5. Age at First Marriage

1.21 Marriage occurs earlier in developing than in developed regions. The age at which fifty percent of girls have married ranges from about 16 in South Asia, 17 in Sub-Saharan

Africa, 18 in Western Asia and 19 in North Africa to above 20 in Latin America. Among five countries in East and Southeast Asia, the median age of girls at first marriage ranged from 16.1 in Indonesia to 22.8 in the Republic of Korea (United Nations, 1987; Lightbourne, *et al.*, 1982; Acsadi and Johnson-Acsadi, 1986; Adlakha, *et al.*, 1992).

1.22 Throughout the developing world, the marriage of girls below age 15 is common. In some cultures, it is all but mandatory. Among 13 African countries with useful data, there were five in which 20 to 39 percent of girls had married by the time they reached age 15. In South Asia, excluding Sri Lanka, the percentage of girls married by age 15 ranged from 25 in Pakistan to 73 in Bangladesh. Proportions of Latin American girls legally married at age 15 are reported to be comparatively small - ranging from four to 13 percent in 13 countries (United Nations, 1987). However, many young Latin American and Caribbean girls form consensual unions while still very young. This pattern of very early marriage of girls, i.e. ages 10 to 17, is detrimental to girls' and women's health (often with maleffects for the remainder of their lives), as well as the health of their children (Acsadi and Johnson-Acsadi, 1990b; Dixon-Mueller and Wasserheit, 1991).

6. The Work Burden

1.23 Where girls are not wanted or are considered to be of little value or an economic disadvantage to their parents and when, owing to customs of early marriage, the benefit of their productivity in adulthood will accrue to their in-laws, many families consider that the girls should pay their way. Hence, the heavy burden of work that is associated with women in developing

regions is experienced first as a small girl and continues throughout the woman's life. The extent that this occurs varies greatly among and within developing countries and among different ethnic and socioeconomic groups. In many settings, little girls are required to perform heavy menial tasks alongside their mothers. They may care for their younger siblings, gather firewood, carry water and assist in animal husbandry as well as perform household chores before old enough to attend school. (UNICEF, 1990, 1991; UNICEF and Sierra Leone, 1989; United Nations Office at Vienna and CEPED, 1992; PAHO, 1983). When it is considered that the same overworked girls are given less food with poorer nutrients than boys and health care that is inferior and dilatory, it is small wonder that they experience higher morbidity and, frequently, higher mortality than boys.

HEALTH CONSEQUENCES

1.24 In many societies, gender is a significant determinant of children's nutritional status. Among the many disadvantages to girls, the withholding of adequate and nutritious food carries some of the more telling consequences. Malnourishment renders its victims susceptible to infections and disease, stunts growth and impedes physiological maturity. In girls, the effect can be far reaching; stunting, weight loss and small pelvis due to malnutrition portend severe difficulties during and following childbirth and may affect low birthweight and the viability of their infants (Ruzicka and Kane, 1986; UNICEF, 1991). Further, severely malnourished girls are as much as four times as likely to die, *ceteris paribus*, as are adequately fed boys (Ruzicka and Kane, 1986.) In some countries, this would have ominous implications for girls.

1.25 Where parents fail to ensure adequate and timely health care for girls compared to their efforts for boys, as is common in most countries in South Asia, among other things, girls lose their natural biological advantage over boys. The result is that the mortality of girls aged 1-4 years, and sometimes older exceeds that of boys. Also in many African and Western Asian countries, owing to health care differences, young girls lose their biological advantage over boys, so that the female under 5 mortality rate approaches that of males.

1.26 Marriage at an early age has a decidedly deleterious effect upon girls' health as well as that of their children. This is particularly so where health standards are low, girls suffer inadequate nutrition and are not given timely and adequate access to competent care during pregnancy and confinement. (Acsadi and Johnson-Acsadi, 1986, 1990b; Starrs and Measham, 1990). In South Asia, much of Africa and Western Asia, girls are required to demonstrate fecundity right after marriage. When girls are below age 16, this invites obstetric problems, miscarriage, stillbirth, (United Nations Office at Vienna and CEPED, 1992; Dixon-Muller and Wasserheit, 1991), impaired health and, occasionally, death (Acsadi and Johnson-Acsadi, 1991). The tradition of early marriage was perpetuated during an era of very high mortality to ensure reproduction. But the custom causes rather than accommodates high mortality.

1.27 Young girls are more susceptible than mature women to sexually transmitted diseases and pelvic inflammatory disease (Dixon-Mueller and Wasserheit, 1991). Subfecundity is also common among young brides. For example, in Bangladesh, Pakistan and Yemen during the mid 1970s, one-half of girls were married by around ages 13, 15 and 16, respectively, but

without contraceptive use, the mean duration between marriage and birth of first child was three to five years, compared two years where average age of girls at marriage was 17 or more years (Acsadi and Johnson-Acsadi, 1986). Clearly, to affect substantial improvements in female health where such customs prevail, marriage patterns much change. Efforts to alter this deeply entrenched convention of early marriage without such institutional changes as expansion of female education and opportunities for formal economic activity will continue to encounter societal obdurateness.

**E. LONG TERM IMPLICATIONS OF GENDER DISCRIMINATION
AND MALTREATMENT IN CHILDHOOD UPON THE PHYSICAL AND
MENTAL HEALTH AND WELL-BEING OF WOMEN**

1.28 The girl's experiences are the woman's heritage. Childhood experiences of malnutrition, inadequate health care, marriage and childbearing are often enfeebling throughout life. One of the principal maladies associated with childbearing by young girls is vesico-vaginal fistula, the symptoms of which are frequently the cause for divorce, social ostracism and consequent poverty and disease (Acsadi and Johnson-Acsadi, 1990b). Discrimination may have such psychological effects upon girls as cause impairments throughout their lives. The literature is replete with references to the low self-esteem that such conditioning creates in females beginning in very early childhood. Discriminatory practices, along with societies' acceptance of these practices imprint upon girls intrinsic feelings of inferiority and worthlessness. It is this evaluation of self that allows girls, and later women, to accept gender inequities. A severely damaged psyche impairs the ability to act decisively whether in the interest of health or other matters.

II. FACTORS DETERMINING ACCESS TO AND USE OF FAMILY PLANNING, HEALTH AND NUTRITION SERVICES

2.1 Family planning is indispensable for good health. The benefits accrue not only to women but to children and families, as well. For sexually active individuals, it is the most dependable, healthiest route to rational childbearing. Maternal illness and death can only occur in the event of a pregnancy. High levels of maternal mortality accompany low levels of contraceptive use and high fertility. Family planning reduces the incidence of risk. (Royston and Armstrong, 1989; Acsadi and Johnson-Acsadi, 1986; IPPF, 1986; Fathalla, *et al.*, 1989).

2.2 Studies have shown that, if women in developing countries with high risk patterns of childbearing were to confine pregnancies to ages 18 to 34, space births two to five years apart and limit family size to three and not more than four children, their health risks would be markedly reduced (Maine, *et al.*, 1987; Trussell and Pebley, 1984; Acsadi and Johnson-Acsadi, 1990; Starrs and Measham, 1990).

A. FACTORS AFFECTING ACCESS TO AND UTILIZATION OF FAMILY PLANNING METHODS

1. Prevalence of Contraceptive Use

2.3 Among developing regions, contraception is most widely practiced in East Asia, where the percentage of couples with the woman of reproductive age that uses some method of contraception ranges from 72 in China to 81 in Hong Kong and averages 72 percent. The comparable averages for other major regions are: other Asia - 40; Northern Africa - 31; Sub-

Saharan Africa - 13; and Latin America and the Caribbean - 57 percent. Within Southern Asia, the range is estimated to be from 2 percent in Afghanistan to 43 percent in India, and 62 percent in Sri Lanka. Among Western Asian countries, it varies from one percent in Yemen to 53 in Lebanon and 63 percent in Turkey. Elsewhere, levels vary from 10 (Haiti) to 70 percent (Barbados and Puerto Rico) in the Caribbean; from 23 (Guatemala) to 70 percent (Costa Rica) in Central America; and from 30 (Bolivia) to 66 percent (Brazil and Colombia) in South America (Weinberger, 1991).

2. Factors That Promote the Practice of Family Planning and That Mitigate Against It

2.4 Throughout the developing regions, many women who say that they want no more children do not take steps to effectuate their desires (Rutenberg, *et al.*, 1991; Westoff, 1991). Such discrepancy is least evident where relatively few women wish to cease childbearing, as in Africa, and where the prevalence of use is comparatively high, as in East Asia.

2.5 The principal social, economic and cultural factors that neutralize the motivation to rational reproductive behavior are mainly a reflection of the status of women in the society. Even religious condemnation of contraceptive use is associated with an ideology that lowers women's status (United Nations Office at Vienna and CEPED, 1992). Factors that deter contraceptive use may be classified roughly as follows:

2.6 a. **Patriarchy** - the social relations that enable men to dominate women, through the control of power and resources, leaving women powerless and dependent on them (Cain,

1979). This condition is present in some degree in all developing societies, and its influence upon contraceptive use is felt in all major developing regions². Polygamy reflects patriarchy, but it does not necessarily impede contraceptive use, as Brown (1981) observed for Sub-Saharan Africa. However, in other regions, as among some Andean peoples of South America it may foster competitive childbearing among wives (UNICEF, 1989) and mitigate against family planning.

2.7 **b. Female seclusion and the separateness of the sexes**, bride price, obligation of the bride to live in the husband's home with his family and denial of the right to control money, even if earned are, *inter alia*, among the terms of patriarchy that impinge upon women's ability to make decisions about and use contraceptives. Where these conditions abound, it almost invariably occurs that women's principal function is that of sexual partner and propagator of the lineage. Some or all these features are found particularly in Bangladesh and Nepal in South Asia (Cain, 1979; UNFPA, 1990), some Middle Eastern Muslim societies (e.g. Lebanon, see Chamie, 1981), and Sudan in North Africa (Naisho, 1981). Bride price is common, albeit declining, in Sub-Saharan Africa and sets the terms of marriage as a woman's obligation to bear children and the husband's ownership of them. (United Nations Office at Vienna and CEPED, 1992; Acsadi and Johnson-Acsadi, 1990a; Caldwell and Caldwell, 1990). Separation of the sexes prevails to some extent throughout the developing regions and is a principal means whereby the lower status of women is consolidated and the childbearing function emphasized (Rivera, 1986; Ward, *et al.*, 1992; United Nations Office at Vienna and CEPED, 1992).

2.8 c. **Childbearing is a status giving phenomenon** for both women and men and is a principal reason for non-use of family planning methods. For women, particularly, status is not easily achieved by other means, if at all, in societies that lay great stress on reproduction as the woman's primary source of social approval and reward. This deters contraceptive use in much of Africa and Western Asia³ (Acsádi, 1976; United Nations, 1987; United Nations Office at Vienna and CEPED, 1992; Caldwell and Caldwell, 1990), and is common in Latin America (Tucker, 1986; Fort, 1989; Madrigal, 1990; Ward, *et al.*, 1992), where male virility and potency are still measured by the number of children fathered, and their wives or partners acquire status by accommodating them. Caribbean women tend to consolidate less stable unions by having a child for each partner, so that the man will give economic support for the entire family (Jamaica, 1979; Guyana, 1975). Bledsoe (1990) also reported that Yoruba women in Nigeria bind their partners by bearing children for them. So crucial is childbearing to women's social and psychological well-being in regions where their status depends upon it that they are unlikely to alter their reproductive patterns so long as all other facets of their lives are unchanged (United Nations Office at Vienna and CEPED, 1992).

2.9 d. **Egalitarianism.** The extent of egalitarianism between spouses also appears to be an important factor in contraceptive use. When expressed as communication and mutual agreement on matters of family planning, its lack has been attributed to culturally imposed female modesty and male dominance as observed in Latin America (CELADE and CFSC, 1972; Hill, *et al.*, 1959; Acsadi, *et al.*, 1991; Ward, *et al.*, 1992), and to patriarchy and low female status in the family in India, Iran, the Philippines and Singapore (United Nations, 1974). This

form of inegalitarianism fosters ignorance of the spouse's family size desires and prevents women from formulating and acting upon their own preferences. Requirements of female modesty also deter the traditionally raised Latin American woman from attending family planning clinics or from even discussing contraceptives, especially if unmarried (Scrimshaw, 1976; Rosenhouse, 1991; United Nations, 1989; Ward, *et al.*, 1992; Rivera, 1986; Fort, 1989). A compelling deterrent to women's use of contraceptives is the belief by husbands that freedom from conception will precipitate wifely disloyalty. This notion is widespread in Sub-Saharan Africa (United Nations Office at Vienna and CEPED, 1992; Acsadi and Johnson-Acsadi, 1990a; Shepherd, 1989, UNICEF and Nigeria, 1990), and in Latin American and Caribbean countries (Folch-Lyon and Trost, 1981; Tucker, 1986; Friedman, *et al.*, 1975).

2.10 e. **Religion** is a powerful deterrent to contraceptive use among the more traditional people of Latin America. The Catholic church offers strong opposition to mechanical and chemical methods of birth control, and is joined in its condemnation by community leaders and other traditionalists (Stycos, 1984; Ward, *et al.*, 1992; PAHO, 1985; Simmons, *et al.*, 1983). Further, the elite are said to have institutionalized this religious perspective in their successful control of political power (Simmons, *et al.*; 1983; Stycos, 1984; IPPF, 1988). In Hindu cultures, contraceptive use may be impeded by religious stress upon the importance of sons for ritual and lineage purposes -causing women to continue childbearing until assured the survival of sons - and the religion supports this tenet by assigning women inferior status (UNICEF, 1990). The pressure for sons is also strong in Islamic societies (United Nations, 1973; United Nations Office at Vienna and CEPED, 1992) but, although Islam does not prohibit birth control, it is open to

individual interpretation, and it supports conditions that are not conducive to contraceptive use (Chamie, 1981; Sachedina, 1990; Obermeyer, 1992). Folk beliefs that children come from God, ancestor worship, belief in reincarnation and in obtaining eternal life through one's descendants are common in African societies (Caldwell and Caldwell, 1990; Acsadi and Johnson-Acsadi, 1990a; Valentine and Revson, 1979). Such beliefs bear directly upon the propensity to control fertility by means other than abstinence during lactation (traditionally aimed to promote child survival) because, in conditions of high infant and child mortality, women must have many children in order to assure the survival of a few.

3. Access to Family Planning Information and Means

2.11 Knowledge of a method of family planning and knowing where to get it do not ensure use, and culturally imposed restraints may deter use even when contraceptives are accessible. Women are frequently thwarted by their husband's negative attitudes, as in Central Africa (United Nations Office at Vienna and CEPED, 1992) and Latin America (Friedman, *et al.*, 1975; Tucker, 1986), by the requirement of husband's approval, as in Nigeria (UNICEF and Nigeria, 1990), Peru (Tucker, 1986), Bangladesh (Bhatia, 1982) and other South Asian societies (UNICEF, 1990), and the fear of reprisals, even divorce in some places, should they exceed the husband's authority.

2.12 Access to family planning services is often prevented by poverty and women's inability to finance even nominal costs of contraceptives or the examinations required to obtain them (Tucker, 1986; Covington, *et al.*, 1986). Social condemnation of family planning that is

found in many communities of Latin America and the Caribbean (IAPG, n.d.) and Sub-Saharan Africa (Caldwell and Caldwell, 1990), for examples, renders physical access to the means of family planning meaningless for many women, who will not risk social censure by going to a family planning clinic. Negative attitudes and discouragement from physicians and other care givers, as noted in respect to substantial numbers of Nigerian doctors (Covington, *et al.*, 1986) thwarts women who would otherwise obtain contraceptives. Similarly, class discrimination among clients and mistreatment of clients by clinic staff cause women to avoid family planning care centers. This has been observed in Kenya (Shepherd, 1989), Nigeria (Okafor and Olukoya, 1992), Peru (Tucker, 1986), Mexico (Folch-Lyon and Trost, 1981), and South Asia (Schuler, *et al.*, 1985, Simmons, *et al.*, 1986), and it prevails widely elsewhere.

2.13 The politics of organized family planning are often partly responsible for the non-acceptance of family planning services. Some writers have noted that family planning staff tend to be elitist and appear oblivious to the cultural values and customs of the people that they serve (as, for examples in Peru - Tucker, 1986; and Nepal - Schuler, *et al.*, 1985); that the movement has been directed toward women, and men have not been sufficiently involved, though they make major family decisions (Carlos and Diallo, 1986); that the Maternal and Child Health (MCH) clinic is not the proper locus for family planning, as men do not frequent the clinics and, moreover, secluded women may not be able to travel to them unless accompanied by men. Additionally, in a great many locales, adolescents, unmarried women and married women without children are unlikely to attend an MCH center and will therefore not have access to family planning service. Moreover, family planning clinics in many countries will not serve

young and/or unmarried females owing to law or social sentiment (United Nations Office at Vienna and CEPED, 1992; Roemer, 1985).

4. Access to Legal Abortion.

2.14 The World Health Organization estimates that each year 40 to 60 million women seek to terminate an unwanted pregnancy and that, as a consequence, from 100,000 to 200,000 succumb to maternal death (Zahr and Royston, 1991). In spite of this widely publicized account, the vast majority of women in developing countries (excluding China) do not have access to legal abortion. Tangential to this situation is the fact that, in many countries, numerous adolescents and unmarried women who are denied access to family planning services are susceptible to unwanted pregnancy. This occurs in Sub-Saharan Africa, South Asia, several countries of South East Asia, including Indonesia, and the Philippines, and much of Latin America (Senderowitz and Paxman, 1985; IAPG, n.d.; Dixon-Mueller, 1990). Even where legal grounds for abortion exist, care providers may interpret the law incorrectly and refuse service or they may be biased against abortion; spousal consent may be withheld; cost may be prohibitive or women's compliance with other requirements unfeasible. (Henshaw, 1990; Dixon-Mueller, 1990; Frejka and Atkin, 1990)

2.15 Lacking access to legal abortion, recourse to illegal means of terminating pregnancy is widespread in Latin America, mainly in Brazil (WGNRR, 1989; Valle Silva, *et al.*, 1990; Fathalla, *et al.*, 1989). Some Latin American women, and no doubt others, risk humiliation, violence or other punishment by spouse or partner if they do not unconditionally accept

intercourse. Once pregnant, abortion is a solution that does not require the consent nor involve the knowledge of partner or spouse (Frejka and Atkin, 1990). And unlike contraceptive use, confession of abortion before a priest is required only once. In fact, several writers have found that in Mexico (Ordóñez, 1975), Chile and elsewhere in the region (Viel, 1975; Frejka and Atkin, 1990) religion does not appear to influence women's decision to have an abortion.

2.16 Mothers with small children and pregnant women are often not employable as domestics, factory workers or in several other types of jobs and, in Latin America, many have an abortion to avoid dismissal. A hospital study in São Paulo, Brazil (Santos, 1981) showed, that most women had been fired after the seventh month of pregnancy, and only about 10 percent were allowed to return to work after delivery.

2.17 In spite of the high value that people in Sub-Saharan Africa place upon children, abortion may be relatively common (Coeytaux, 1988), both among older women and secondary school girls. The latter are ignorant of family planning, their partners are disinterested in it (Makinwa-Adebusoye, 1992), and dismissal from school is the penalty for pregnancy (Liskin, 1980). These factors have increased clandestine abortion among school girls, who want to finish school and to avoid the disgrace of premarital pregnancy (Dixon-Mueller, 1990).

2.18 Along with the narrow provisions for legal abortion, women in most Asian countries who have an unwanted pregnancy may find the conditions or terms for legal recourse unacceptable or inconvenient. Validation of legal entitlement, lack of privacy, and an impersonal

atmosphere discourage many, and unmarried women are often reluctant to visit a clinic for fear of social censure. Hence, there is wide resort to risky, clandestine abortion (Liskin, 1980). In Middle Eastern countries, a pregnant unmarried woman may risk death at the hands of male relatives whose honor she has tarnished; illegal abortion is her only option.

2.19 Owing to a need for anonymity or due to cost consideration, many women either abort themselves, or obtain the services of traditional midwives, *dais*, traditional healers and assorted persons with no medical training or health care background, who use crude methods (Liskin, 1980; Dixon-Mueller, 1990) often with dire consequences.

2.20 Access to adequate post-abortion service can be impeded by many factors, including the need for secrecy to avoid legal and social censure, and the inability, *sui juris*, to take timely and effective action. The literature does not reveal instances of hospital refusal of women suffering the effects of botched abortions, possibly because they are not reported. However, there is evidence that, owing to the frequency of such cases and to the cost that hospitals incur in funds and medical resources, premature discharge is common and occurs in all regions (Winikoff, *et al.*, 1991; Rizo, 1992).

5. **Female Autonomy**

2.21 The family and the community determine the bounds within which individuals may act autonomously. Whether a woman has access to good health care and can utilize it often depends upon the extent of autonomy that she is able to exercise. Educational attainment and

employment in income generating positions, for examples, are status conferring mechanisms and they contribute to the capacity to make independent decisions and actions in health and other matters. But higher social status is not to be confused with female autonomy. The latter implies that one may act in one's own right and on one's own behalf, rights not even accorded to well educated, professional women in some societies. Caldwell (1986) noted that where there is female autonomy, women are more likely to secure good health and nutrition for themselves and unlikely to discriminate against their daughters. Women enjoy considerable autonomy in the English speaking Caribbean region buttressed among others things by the family structure and the pattern of emigration (Charbit, 1984; United Nations, 1990), while «machismo» and female submissiveness deter it in Latin America (Madrigal, 1990).

2.22 Earned income does not necessarily imply any measure of independence. Frank (1989) found that although Sub-Saharan African women are economically responsible, they are dependent in the functional structure of the family. Further, earning income may have little or no effect upon female status. From findings for a country in each of the major developing regions, Greenhalgh (1991) concluded that there were often prior family claims on women's earnings, leaving them little for themselves, and that women's informal sector employment - so common in these regions - does not promote their autonomy. Ghanaian women farm, but do not have the right to sell their farm crops and, despite the "significant contribution" that women in Lesotho make to household income, expenditure decisions are dominated by men (Rahman, 1992). This is a common but not universal pattern in Sub-Saharan Africa (Jacobson, 1992; UNICEF, 1989a). In Nigeria, Yoruba women are "the trade specialists, as they always had been

traditionally" (Ojo, 1966, p. 102) and the farmer's wife is responsible for selling the farm products, for which she usually receives a commission (Fadipe, 1970). In Sierra Leone women do gain some independence and may amass wealth from the produce grown on lands set aside for them (UNICEF and Sierra Leone, 1989). However, in Sierra Leone, this advantage does not appear to eliminate gender differences in intra-family food allotments. Writing of conditions in Tamil Nadu in South India, Basu (1989) associated women's [greater] autonomy with less evidence of gender differences in parenting.⁴

B. FACTORS THAT INFLUENCE ACCESS TO AND UTILIZATION OF HEALTH CARE FACILITIES

2.23 Social determinants, including individuals' roles in the family and society, are important predictors of mortality and, *a priori*, of health as well. Yet, there is a dearth of information about conditions that promote or are detrimental to general health care of women in developing countries and about health and nutritional status of women outside the context of maternity. With minor and very recent exceptions, researchers, governments and international organizations when dealing with the issue of women's health - whether in data collection and reporting, technical assistance or supplemental programs - have tended to focus on pregnant and lactating women with cursory attention to others. As one researcher declared: "Perhaps the most common indicator of *women's* health status [not *reproductive* health status] is the rate of maternal mortality..." (Rahman, 1992, p. 7). This predilection reflects the failure of both scholars and policy makers to see women as people and not merely as childbearers and to consider their health needs when they have passed the childbearing years. They have legitimated cultural attitudes about the "role" of women.⁵ While ensuring safe motherhood is, indeed, indispensable to the

improvement of both maternal health and female health in general, a singular focus upon certain population groups (e.g. children, women who are pregnant or lactating) or on a particular health problem tends to divert attention from other pressing problems. Indeed, it is held that, in the ICDS program in India, for example, children take precedence over care and coverage of women (World Bank memo, 1992). Of Sub-Saharan Africa, one writer noted: "This pattern [of health service] suggests that more importance is attached to child survival as compared to maternal health by the women themselves, and indeed by their communities and countries at large" (Mhloyi, 1990, p. 10).

1. Cultural Perspectives as to What is Normal Health for Women

2.24 Ailments that afflict women in developing countries, especially for those in rural areas, are often taken for granted even in pregnancy. The community, and the women themselves consider this as their lot. Hypertension, obesity and diabetes among women are accepted as normal condition in some countries, particularly where widespread, as in Jamaica (Walker, *et al.*, 1987), and Trinidad and Tobago (PAHO, 1990, v. II). Surveys conducted in Colombia, Peru and Mexico have disclosed that women experience a wide variety of vaginal disorders of which discharge, itching, excessive bleeding and other discomforts are often viewed simply as "women's problems" by the women and their spouses (Gomez, 1986; Ochoa and Gill, 1981). Many rural African women suffer the effects of hookworm, pesticides, malaria, and other health hazards while continuing to perform household chores, parental and wifely duties without taking or being given recourse to health practitioners (Stinson, 1986, United Nations Office at Vienna, 1988; UNICEF and Nigeria, 1990)).

1990-1991
1992-1993



2.25 Throughout South Asia, with the possible exception of Kerala in India, Maldives and Sri Lanka, illness and pain, including domestic violence, have been perceived as girls' and women's lot and ordinarily not of sufficient importance to warrant medical attention and, in many circumstances, not even traditional health care (UNICEF, 1990; Murthy, 1982; Stinson, 1986), nor judicial intervention in case of violence.

2.26 In South Asia, dowry deaths and bride burning may be reported as suicides by husbands who are dissatisfied with the amount of dowry payment (Heise, in press). The perpetrators of these acts of violence against women often do so with impunity. Wife beating and other abuse also appears to be widespread in other regions. Many Sub-Saharan African men justify it by the bride price paid. The practice is also common throughout Latin America, the Caribbean, and East and South East Asia; it accounts in good measure for the prevalence of suicides among women of childbearing age and, in some Latin American countries, for women's alcohol abuse as well (Heise, 1989). Circumcision, to which millions of young girls in Africa, Western Asia, and parts of South-East Asia are subjected, frequently without benefit of anesthesia and with unclean instruments, is performed to assure the chastity and loyalty of wives by reducing their sexuality. The health risk involved in this surgery is enormous; hemorrhage, tetanus, and death are real possibilities. There may also be consequent difficulties during childbirth.

2.27 Mental ill health among girls and women in developing countries is a widely tolerated occurrence. And, as with other illness, it is tolerated more often without intervention,

because it typically derives from the status of females and their social roles (see Paltiel, 1987; in press), both of which are institutionalized societal patterns.

2. Factors Affecting Health Priorities

2.28 In most developing countries in which patriarchy characterizes society, the adult male's personal needs and wishes take precedence over the requirements and concerns of women and other family members. Hindu teachings give husbands a much superior position to that of wives and advises that women should sacrifice for husband and family (Khan, *et al.*, 1989). This inequality extends to the favoritism of boys over adult women and girls in the consumption of family resources, and to the more neglectful parenting of girls than boys. The more extreme examples are in South Asia (Acsadi and Johnson-Acsadi, 1990), but aspects exists with deleterious effects also in Latin America and Sub-Saharan Africa (Caldwell, 1986; Caldwell and Caldwell, 1990; Mhloyi, 1990; UNICEF, 1990; Cleland, *et al.*, 1983; PAHO, 1983).

3. Customs and Other Factors That Affect the Options That Females Have for Dealing with Their Health Problems

2.29 It is common in countries of South Asia, in some Islamic societies and, to a lesser extent, in Sub-Saharan Africa that young wives residing with their in-laws are not allowed to make decisions pertinent to health care for themselves or their children. This authority is reserved for the mother-in-law, other older women in the household, the husband or a male relative or, in case of pregnancy, even for the community. A man may even describe his wife's ailment to a health practitioner and obtain the medicine himself. (Stinson, 1986; Murthy, 1982; Leslie and Gupta, 1989; Santow, 1992; Mhloyi, 1990; Khan, *et al.*, 1989). In India, the beliefs of male

physicians and others about the disease resistant capacity of women often compromise the validity of women's articulated needs for health care (Murthy, 1982). In some cultures, custom requires and male relatives demand that women be seen only by female health care givers. But other customs and traditions in the same societies hinder the proper training of female health care givers, including physicians, so that women are deprived of adequate care. This "catch 22" has been observed in the Sudan (Naisho, 1981), the Sahel countries of Central Africa (United Nations Office at Vienna and CEPED, 1992) and some Muslim countries (Aral and Guinan, 1981). In Bangladesh, many rural women are said to die of maternal causes, because they cannot be examined by a man and no woman doctor is available (Acsadi and Johnson-Acsadi, 1990). Culturally prescribed female modesty limits the options that many Latin American girls and women have for obtaining health care: disrobing, exposure of the genitals or being examined by a male physician - and in some cases, any stranger - are unacceptable (Schrimshaw, 1976; Rosenhaus, 1991). Consequently, many suffer for lack of preventive as well as curative care.

2.30 In these countries, men tend to dictate the timing and terms of coitus. Women may not therefore have the right to refuse intercourse with their spouse or partner nor to demand the use of a condom, and their exposure to sexually transmitted disease (STD) by unfaithful mates - whose infidelity society does not penalize - is common. This is held to account, at least in part, for the wide prevalence of STDs among women in Latin America and the Caribbean, parts of South and Southeast Asia and Sub-Saharan Africa and to account for infertility in Central and West Africa (Palloni and Lee, 1992; Aral and Guinan, 1981; United Nations Office at Vienna and CEPED, 1992). Payment of bride price, common in arranged African and Middle Eastern

marriages, encourages the wedding of young girls to older, wealthy men among whom the incidence of STDs is greater than is the case with younger men (Palloni and Lee, 1992). Further, the poverty that forces young girls in some countries into prostitution also contributes to STDs and AIDS among them and, through them, to wives or partners of their clients (United Nations, 1991a; UNICEF, 1991).

4. Factors That Influence Women's Ability and Freedom to Identify Their Health Care Needs, Select and Use Health Care Services

2.31 Mores and traditions can put effective brakes upon efforts to improve women's health, because illiteracy and low levels of educational attainment deprive women of both the will and the ability to circumvent customary barriers. IF parents do not provide formal schooling for their daughters, women will be incapable of dealing aptly with either their own health problems or those of their children and, circumambiently, will place their daughters in similar jeopardy. The gender inequity in primary schooling has been declining in recent years (United Nations, 1991; ECLA, 1992) but, as noted earlier, the marriage of girls at excessively early ages, an impediment to their schooling, persists in many places, particularly South Asia, North Africa and the Middle East (United Nations, 1987; United Nations Office at Vienna, 1989; Acsadi and Johnson-Acsadi, 1986). Society's insistence upon this tradition is a principal deterrent to female autonomy, and curtails women's freedom of choice about most matters of importance to them, including access to and utilization of health services for themselves and for their daughters and the option to escape domestic violence.

2.32 Women in Sub-Saharan Africa, particularly rural places, depend upon older women for advice about their health, but older women are typically traditionalists with limited formal education, and with little knowledge of and/or confidence in modern medicine. Another problem is that, the work burden deprives many Latin American, South Asian and Sub-Saharan African women of the time and energy to utilize available health services (Giorgis, 1981; PAHO, 1983; Rutabanzibwa-Ngaiza, et al., 1985; UNICEF, 1990; Stinson, 1986).

2.33 Women's utilization of health services is often deterred by lack of money. Even when women are earners, they may reap no personal gain from their labors. In Sub-Saharan Africa, they are responsible for the welfare of their families without regard to their capacity effectively to shoulder this responsibility. (Valentine and Revson, 1979; Stinson, 1986; Shaw-Taylor, 1981; Jacobson, 1992). Hence, the women take care of their own health needs last, if at all. A United Nations publication (1991a, p. 189) characterizes women as often being "the poorest of the poor" (see also UNICEF, 1991). It notes further that approximately one-third of all households in developing regions are headed by women and that, in rural Africa and the urban slums of Latin America, the number is closer to one-half. Members of poor, female headed households typically have inadequate health care.

5. Factors Affecting Access to Care That Is Required for Safe Motherhood

2.34 Women in developing countries fulfill many roles but, for many, childbearing is the *raison d'être* given them by society. Yet, when fulfilling this function, their comfort and well being are often discounted and, as noted above, the care given them even during confinement

does not bespeak the importance that the family, community and society attach to this cardinal role.

2.35 Throughout developing regions and especially among rural and village people, there are traditional beliefs about childbearing that conflict with modern science and medicine. For example, it is widely believed that pregnancy is not a condition that requires medical care, which is sought only in cases of severe illness (Khan, *et al.*, 1989; United Nations, 1986). Where this notion prevails, relatively few women have the benefit of prenatal care by modern health care providers. Hot foods, cold foods, eggs, certain fruits and leafy vegetables, even milk may be contraindicated during pregnancy and reduced calorie intake advised in compliance with traditions in Sub-Saharan Africa, Arab Gulf countries and Andean countries of South America and in contrast to the teachings of modern medicine (Cosminsky, 1986; Mhloyi, 1990; United Nations, 1986). Rural Latin American women receive prenatal care from the traditional birth attendant, but descriptions of this care (Cosminsky, 1986) indicate that its value must be essentially psychological.

2.36 Women's use of prenatal care facilities may also be restricted by the necessity for social seclusion and/or the custom that a male relative must accompany them when travelling, as in some Arab, rural Latin American and South Asian countries. The requirement that care must be given by a woman has hindered the development and use of MCH services for Saudi Arabian women (Leslie and Gupta, 1989). Motherhood is also made less safe by strenuous work

up until the onset of labor and the preferential feeding of men and children to the disadvantage of the pregnant woman (Mason, 1984; Santow, 1992; United Nations, 1986; Khan, *et al.*, 1989).

2.37 Many African, Latin American and Asian women are said to prefer traditional birth attendants (TBAs) or *dais* for care during confinement, though untold numbers are attended by relatives. Some health care providers support aspects of this custom (see, e.g. Leslie and Gupta, 1989), but other scholars criticize the practices. For instance, Harrison (1990) maintains that this preference reflects the women's low level of education and impoverished economic condition, and that TBAs should be replaced by trained midwives (see also Mhloyi, 1990 on conditions in Africa; and Rhinehart and Kols, 1984; Cosminsky, 1986; Murillo and Castillo, 1982 for Latin America). In some societies, the belief appears to be common that most any older woman can give competent assistance at delivery. However, TBAs, *dais*, and other untrained delivery assistants are often associated with dangerous, insanitary practices (working with unclean hands, inserting unclean objects into the vagina, giving toxic herbal medicines to shorten labor, improper and insanitary cord cutting, holding the woman upside down, etc.), and they usually view a difficult labor as the result of the woman's infidelity, and a disease as being the influence of evil spirits, curses and witchcraft curable only by incantations and rituals (United Nations, 1986; Cosminsky, 1986; Acsadi, *et al.*, 1991).

2.38 The custom that sends women to their parental home during late pregnancy and confinement to be under their mothers' care serves to perpetuate traditional practices. Superstitions pertaining to the placenta and disposal of the cord are said to account in some

measure for the underutilization of rural medical facilities and for women's preference for traditional care in Colombia, Mexico and Peru (Cosminsky, 1986). The preference for home based births and traditional care at confinement, common among rural women in developing regions, frequently restricts the possibility of shifting successfully to appropriate, higher level care when complications arise.

**C. FACTORS DETERMINING WOMEN'S NUTRITIONAL STATUS
AND THEIR ACCESS TO AND USE OF NUTRITION SERVICES**

2.39 It has been estimated that anemia is prevalent in one form or another in 47 percent of women aged 15-49 in developing countries and in 59 percent of those who were pregnant compared to 26 percent of men aged 15-59 years. Malnutrition among women is most widely prevalent in South Asia and Sub-Saharan Africa (De Maeyer and Adiels-Tegman, 1985). It is attributable to a variety of factors, including poverty, ignorance and superstition. And, although gender differences in adult nutritional levels, particularly in iron deficiency, do reflect women's special nutritional needs, much of the gender disparity is due to the fact that women do not receive an adequate share of the food available to their families.

2.40 Over the past several decades, governments, non-governmental organizations and intergovernmental agencies have implemented numerous nutrition and nutrition *cum* health schemes for the indigent in developing regions. Most such programs have aimed to support children under age 5, pregnant women and lactating mothers. Whether other women were able

to obtain and utilize food and nutritional supplements intended for the poor at large is difficult to determine, as available reports rarely reflect it.

2.41 In 26 Latin American and Caribbean countries, for example, there were 126 food aid programs during 1970-1984, of which 94 percent were nutritional supplement schemes and 6 percent were general food subsidies for poor populations (PAHO, 1990a). However, available reports give no indications as to women's access to and use of the programs. Girls benefitted through school lunch programs and mothers, pregnant, and postnatal women could benefit through attendance at MCH centres. An analysis of the effects of one such intervention, however, does shed some light on the potential benefits to females. Pebley and Amin (1991) noted that in the Narangwal nutrition and population project (conducted in 5 Indian villages), girls gained markedly. When children with weight deficiencies did not attend the centers, health workers went to the home, overrode the family food allocation system and fed the children themselves; they did not discriminate in favor of boys.

2.42 Conversely, in the Matlab, Bangladesh project, families were expected to take children with poor growth patterns to the centres, with the effect that the benefits of added nutrition accrued to sons to a greater extent than to daughters. The low status of and value attached to women explain the fact that in Bangladesh there is "consistent and systematic discrimination against females in all age groups" (Chen, *et al.*, 1989, p. 159). Indeed, it has been suggested that, in strong male preference cultures, men may actually benefit more from food programs than the children for whom they are intended (Pebley and Amin, 1991).

2.43 The El Progreso project in Guatemala provided food supplements to children under 7 years old and to pregnant and nursing women. No special provisions appear to have been made to ensure equity between boys and girls, and evaluations have indicated that none were needed (Pebley, 1984).

D. OLDER WOMAN

2.44 A search of the relevant literature and computerized information retrieval systems revealed little about the health and nutrition needs of and services for older women, verifying that both researchers and policy-making officials have given little attention to the requirement of women over age 49. One hundred and six million, or 53.8 percent of the people in developing countries who were aged 65 and over in 1990 were women (United Nations, 1992a), among many of whom hunger and malnourishment were rife. Where biases in the family allocation of food and resources and of health care exist, they are more pronounced in the case of older women. Abandonment or widowhood often leaves older women destitute and, among some lower socioeconomic groups in South Asia, she may have to beg for food (Merchant and Kurz, in press). In some Nigerian cultural groups (UNICEF and Nigeria, 1990), and perhaps among other peoples of Sub-Saharan Africa, widowed women not in a levirate system and aged women without pension or insurance may live in abject poverty, lacking even the most elementary amenities and without adequate food or health care.

2.45 The belief that families in Africa always take care of their aged members is held to be more or less a myth (UNICEF and Nigeria, 1990). Respect and care for the aged may not

be the rule in other developing regions. Koblinsky and her colleagues noted that, as women in developing regions become increasingly less productive with age, neglect by family and society also increases (Koblinsky, *et al.*, in press). And although older women's need for health care and nutritional supplements is considerable, access to them declines. In some parts of India, older women (and men) are treated as a burden, particularly when ill (Khan, *et al.*, 1989). Women of advanced age may experience the cumulative effects of a lifetime of nutritional deprivation (Merchant and Kurz, in press; Chen, *et al.*, 1989) which, along with a hazardous and work burdened life, continuous childbearing and no sense of self-worth leaves them frail both physically and mentally (WHO, 1985; Ruzicka and Kane, 1986).

III. LAWS AND POLICIES AFFECTING FEMALE HEALTH

3.1 In the following, the words «laws and policies» refer to legal and official documents, including decrees, ordinances, regulations, development plans, government programmes, and judicial decisions, as well as to government statements, international resolutions, conventions and other instruments. The main sources of laws affecting female health are the Civil Codes or Family Codes that contain provisions concerning, among others, marriage and the rights, duties and parental authority of the spouses. Criminal Codes may also include several provisions for offenses that affect female health. Policies that are manifested in national development plans and government programs are intended to affect female health both directly (e.g. by family planning programs, nutrition programs, provisions for maternal health care) and indirectly (promoting gender equality, especially in education and employment). International instruments concerning female health often pave the way for national legislation.

A. LEGISLATION CONCERNING MARRIAGE AND FAMILY

1. Legal Minimum Age at Marriage

3.2 Marriage is a type of contract, the usual legal stipulation for contracting it is that the contracting parties should be free of coercion, and have the legal capacity to make a contract, i.e they should have reached the age of majority. Legislation often codifies principles or sets up goals to establish norms that will affect the behavior of people but, more often, it accedes to existing customs. The Honduran Family Code 1984 (Decree No. 76-84), for example, stated in Article 16 that:

"The age of majority is 21 years. Only people who have reached the age of majority have free capacity to contract marriage. However, an eighteen year old man or a sixteen year old woman can contract marriage, if proper authorization is obtained in conformity with the present Code." (Boland and Stepan, 1991, p. 389)

The authorization required is usually parental (or guardians' or adopters') consent and/or authorization by the judiciary. Article 16 of the Honduran Code, however, made further allowances for the prevailing customs by stating:

"In cases, where the spouses, despite being younger than the ages described in the preceding paragraph, have been living together for one month after the youngest spouse reaches 16 years of age; or in cases where the woman becomes pregnant before that age (16 years old), the marriage will be valid without the need for express declaration."
(*Op. cit.*)

3.3 The Honduran law is not alone in making concessions to the prevailing customs. The Natal Code of Zulu Law (Proclamation No. R. 151, 1987), for example, even reversed the requirement of being a major when contracting marriage by stipulating in Chapter 4 that "a Black shall become a major in law on marriage" (Boland and Stepan, 1991, p. 420). Indeed, it is reported that, in the majority of the countries, including those in the developed regions, a minimum legal age is established for those minors who obtain parental consent (United Nations, 1991c). The difference between the legal age without and with parental consent (the minimum legal age) can be considerable. In Chile, for example, the legal age of contracting marriage is 21 years but, with proper consent, even a 12 years old girl may marry.

3.4 Owing to concessions made to custom, the minimum legal age is, on the average, only 16.5 years in 94 countries and areas in the less developed regions. In two-thirds of these countries, it is legally possible for a 17 year old or younger teenage girl to contract a marriage, and in 30 countries to marry as a 15 years old or even younger with parental consent. To marry and to conceive at such ages are clearly disadvantageous for the girls, and endanger their health, as well as that of their offsprings.

Table 3: Developing countries and areas by minimum legal age at marriage with or without parental consent

Legal age	Africa	Asia	Americas	Oceania	Total
12-15	8	6	16	-	30
16-17	13	9	7	3	32
18-21	16	11	5	-	32
NA	13	12	8	9	42
Total	50	38	36	12	136
Average age	17.2	16.8	15.4	16.0	16.5

3.5 Most Latin American and Caribbean countries allow girls to contract marriage with consent at very low ages and, on the average, the legal mini-

imum age is lowest in this continent (15.4 years). In Asia, the legal minimum ages are higher (16.8 years), due to an earlier effort to limit fertility by raising legal age of marriage for females. In Nepal, for example, a government approved population policy goal stated: "HMG has accepted, in principle, that the minimum age of marriage for females should be raised from 16 years at present to 20 years in view of its effect on fertility." (Boland and Stepan, 1991, p.

NA = Information not available.

Sources: United Nations, 1989, 1991c; Boland and Stepan, 1991.

279) As a result of international and African regional efforts (UNECA, 1990), the average legal minimum age of marriage is now highest in Africa, more than 17 years.

3.6 In all but a few countries, the trend is toward raising the legal minimum age of marriage for girls. In 24 countries, for example, where the legal minimum age of marriage reported in the years 1976-86 was, on the average, 13.4 years, it has recently been raised to 17.5 years. However, there has been no change in 20 others, the average age remaining at 15.2 years (United Nations, 1989, 1991c; Boland and Stepan, 1991). Raising the legal age of marriage, however does not mean, that it is enforced, especially as regards customary or common law marriages, consensual unions and cohabitation in general. In Liberia, for example, where the legal age of marriage for women was 18 years (though it varied among different groups, if consent was required), a 1988 Act approving the National Policy on Population for Social and Economic Development set a population policy target to "reduce the proportion of women who marry before the age of 18 years by 50 percent by the year of 2000" (Boland and Stepan, 1991, p. 264).

3.7 One of the reasons for establishing and enforcing legislation on legal age of marriage is the concern for early childbearing. In China, following a State Family Planning Commission Document on illegal marriages in 1987, provincial authorities in Hunan (China) issued a circular, calling on government departments at all levels to investigate the problem of early childbearing and to manage the problems of unregistered cohabiting and of unmarried mothers. The Circular recommended that:

"It is necessary to criticize and educate, and even punish by discipline, those parents who connive with their sons and daughters in practicing unregistered cohabiting." The circular also stated that "It is necessary to keep a strict check on registry personnel" and "those who violate laws and discipline ... resulting in early marriage and childbearing, must be dealt with strictly." (Boland and Stepan, 1991, p. 64)

2. Gender Equality in Marital Rights and Duties

3.8 It is essential from the viewpoint of female health that the legal system should recognize equality of husband and wife in marriage. Without such recognition, women may be unable to make decisions resulting in proper health care for themselves and for their children. In some legal systems family law expressly promulgates gender equality in marital rights and duties. The Honduran Family Code, 1984 (Decree No. 76-84), for example, stated that:

"Art. 40. Marriage is constituted according to the principle of the equality of rights and obligations of both spouses."

"Art. 43. Both spouses have the right to exercise their profession or skill and have the duty to cooperate and help each other to this end... But in any case, both spouses will take care to organize home life so that such activities are coordinated with fulfilling the obligations imposed by this Code."

"Art. 44. The wife will always have a preferential right to the salary, wages, or income of her husband in the amount necessary for her support and that of their minor children. The husband has the same right..." (Boland and Stepan, 1991, p. 391)

3.9 Laws often stipulate different legal ages of marriage for women and men. Among 90 developing countries for which recent data are available, only in 28 was the legal minimum age the same for both sexes. Where different legal ages of marriage are stipulated for men and women, it is always the women who are permitted to marry earlier. In 62 developing countries, the minimum legal age is, on the average, 2.4 years higher for men than for women, as a concession to marriage customs that sanction an age difference between husband and wife, which

is one basis for establishing male dominance in the family. Such principles are often embodied in the Family Code. Examples of such codification:

Rwanda (First Book of the Civil Code): "The husband is the head of the marital community... The wife assist her husband in assuring the moral and material direction of the household and providing for its maintenance." However: "Marriage does not change the civil capacity of the spouses." (Boland and Stepan, 1991. p. 410)

Zaire (Act No. 87-010 setting forth the Family Code): "The husband shall be the head of the household. He owes protection to his wife; the wife owes obedience to her husband. 445. Under the leadership of the husband the spouses shall work together in the interest of the household... The wife must obtain permission from her husband for any legal acts she is obligated to carry out in person." (*op. cit.* pp. 448-449)

Gender inequality may also be detected in other continents. It was necessary, for example, that The Asian Beijing Forum Declaration (1987) should call for initiating and supporting action for:

"Abrogation or removal of laws, rules, regulations, customs and practices that discriminate against women or limit their access on an equal basis with men to opportunities in health, education and employment." (Boland and Stepan, 1991, p. 248)

3. **Violence in the Family and Society Against Women**

3.10 Domestic violence, usually inflicted on the weakest members of the family, is common in all regions. The victims of violence in the family are often women with dire consequences, even death. According to a review of 15 countries in the developed and 22 countries in the less developed regions, several types of violence against women have been reported, among them most reports concerned violence in the family (see domestic violence and homicide in the family in Table 4).

3.11 So many countries are now recognizing the occurrence of significant violence against women in the family, even if it goes unreported, that several international instruments

Table 4: Countries by types
of violence reported against women

Types of violence	Number of countries	
	----- developed	developing
Domestic violence	11	18
Homicide in family	7	8
Sexual assault, rape	9	8
Sexual harassment	7	1
Incest	5	4

Total	15	22

Source: United Nations, 1991, p. 19.

are focused on this problem. The Nairobi Forward-looking Strategies for the Advancement of women stated that violence against women in family and society is a major obstacle to the achievement of the objectives of the United Nations Decade for Women (United Nations, 1989a). The United Nations Economic and Social Council in Resolution No. 1988/27 urged steps toward eliminating this obstacle.

3.12 Whether committed in or outside the family, most countries' criminal code provides deterrent punishment for crimes and offenses against women that may have serious health consequences, such as rape, sexual assault, sexual intercourse with a minor girl or mentally defective woman. Some criminal codes also contain provisions against prostitution, kidnapping and trafficking in women, etc.

3.13 In some countries, special legislation was required to eliminate life threatening or murderous traditional or customary practices against women. India, for example, enacted the Commission of Sati (Prevention) Act (No. 3 of 1988) to punish any person, who abets the commission of sati (the burning or burying alive of a woman with the deceased husband or relative) with death or life imprisonment and fine. The dowry is often a cause of beating or even

killing a woman. Bangladesh, for example amended the Cruelty to Women Act (Amendment Act, No. 37 of 1988), which included, among others, punishment for causing death or grievous hurt for dowry (Section 6). Such laws, however, do not necessarily extend to other cruelties against women. The Supreme Court, High Court Division in Bangladesh, for example, upheld a lower court ruling (the case of Firoza Begum v. Hormus Ali) that dismissed the suit of a woman who testified that the husband beat her while demanding dowry and ousted her from the house. The ruling was that the wife had not alleged that the defendant had "cause[d] or attempt[ed] to cause death or grievous hurt... for dowry", as required by the Ordinance, and that the wife had no right to appeal the decision of the lower court, because it could be appealed only by the Government. (Boland and Stepan, 1991, p. 142.)

B. LAWS AND POLICIES CONCERNING REPRODUCTION

3.14 Separation of legal systems from religious rules is a relatively new development and, in Muslim countries, legislation tends to be in accordance with religion. In Pakistan, for example, it is a constitutional requirement that the laws should be consistent with Islam (UNFPA, 1990). Several principles of some other legal systems are built on the ten commandments. The blessing given in the book of Genesis, «be fruitful and multiply and replenish the world» has also become a tenet governing laws and policies concerning reproduction. With the separation of church and state, and as the world, indeed, became «replenished», the provisions to prohibit birth control (i.e. contraception and voluntary termination of pregnancy) almost disappeared from most legal systems, although its remnants, especially those that impose regulations, still linger in many.

1. Family Planning and Contraception.

3.15 Most recent data on contraceptive prevalence in developing countries show a considerable increase in contraceptive use during the past two decades (United Nations, 1992a;

Table 5. Government policies in developing countries concerning effective use of modern methods of fertility control, 1990

Policy	Africa	Americas	Asia	Oceania	Total
Access limited	-	-	5	-	5
No support	4	1	5	-	10
Indirect support	6	3	2	-	11
Direct support	42	29	24	9	104
Total	52	33	36	9	130

Source: United Nations, 1992a, pp. 97-100.

Mauldin and Ross, 1991)). This trend is a result of changing government policies concerning fertility regulation and family planning programmes. According to the results of the United Nations most recent Population

Inquiry and a review of

other sources in 1990, the use of modern methods of fertility regulation were supported in 80 percent of the developing countries, and in only five countries was access to modern methods limited (Table 5).

3.16 The five countries that limit access to modern methods of fertility regulation are: Mongolia, Cambodia, Lao DR, Saudi Arabia and Iraq. The countries where no support is provided are Bolivia in Latin America, some Muslim countries and a few countries formerly under French rule in Asia and Africa. In Muslim countries, there is certain ambiguity about birth

control. The Koran contains no explicit prohibition against birth control but has general statements about improving human life, and the Hadits, the second source of law to Shariah, gives instances showing that the Prophet permitted coitus interruptus. Thus, there is an almost general agreement that contraceptive practice is proper, and it is usually classified as permitted or disapproved but not forbidden. Conservative Muslim scholars, however, argue that contraception serves to frustrate the Creator's will and reflects lack of faith (Sachedina, 1990; Obermeyer, 1992). In other countries, even where contraception is supported, there also are legal obstacles to practicing contraception in the form of regulations. Legislation may impose (1) requirements for a physician's prescription, (2) restrictions on the place of sale or distribution of contraceptives and (3) on the system of financing contraceptive services. Such restrictive legislation often restrict access to contraceptive methods and services (Roemer, 1985).

2. Termination of Pregnancy.

3.17 In principle, inducing abortion in most developing countries is a criminal offense, for which usually both the woman and the person who induced the abortion are punishable with varying length of imprisonment. Even in countries where induced abortion is legally permitted on request of the pregnant woman, it is subject to certain conditions. In Cuba, for example, where abortion is legally available on request, the *conditio sine qua non* is that the abortion should be performed according to health regulations:

Act. No. 62, Penal Code, 1987: "Art. 267. (1) Anyone who induces an abortion on a women or in any way destroys an embryo, with the woman's consent, and in disregard of the health regulation established for the performance of an abortion will receive a prison sentence ranging from 3 months to 1 year, or a fine of 100 to 300 quotas." (Boland and Stepan, 1991, p.309)

3.18 Another condition is that the abortion should be performed only prior to viability of the fetus. More often, however, not viability but a certain specific gestational period is the criterion that limits the legality of abortion. The period during which abortion can be legally executed is often the first trimester, though in some countries, it must be done within a shorter gestational period, while in others, longer periods are allowed. For examples, abortion can be legally induced only during the first 10 weeks in Cuba and Turkey, and during the first 24 weeks in Singapore. Although gestational limits are not established in China and Viet Nam, most abortions in China are also performed during the first trimester. In those Muslim countries where abortion is permitted, it should be induced before «ensoulment», in Tunisia, for example, during the first three months or 12 weeks (Henshaw and Morrow, 1990; Obermeyer, 1992; Sachedina, 1990). A third kind of restriction concerns certain groups of women (e.g. minors), who are required to produce parental, juridical or other consent (Roemer, 1985).

3.19 Table 6 provides a broad picture of and indications as to the legality or permissibility of induced abortions in developing countries⁶. In most cases, the sums of the three columns showing where abortion is legal 1) on request of the woman, 2) if pregnancy endangers the health of the woman, and 3) if pregnancy endangers the life of the woman equal the total number of countries. The only exception is Uruguay in Latin America, where neither of these legal grounds is recognized but, penalty may be waived when abortion is performed during the first trimester because of serious economic difficulty (Henshaw and Morrow, 1990). The last three columns in the table show the legal grounds in addition to health (including a hazard to life) reasons. In most developed countries abortion is available either on request of the woman or for

Table 6: Countries by legality of induced abortions

Regions	Total number of countries	Induced abortion is legal on ground of					
		request	health of woman	woman's life	social- medical	juri- dical (rape)	eugenic (fetal health)
World	146	25	62	58	20	33	30
Developed regions	32	17	14	1	8	8	7
Developing regions	114	8	48	57	12	25	23
Developing regions:							
Africa	45	2	22	21	3	7	8
Americas	30	2	10	17	4	11	4
Asia, Oceania	39	4	16	19	5	7	11

Sources: Henshaw and Morrow, 1990; United Nations, 1992d; Boland and Stepan, 1991.

health reasons. In the developing regions, however, one-half of the countries permit abortion only if the pregnancy threatens the woman's life. Many of these least permissive countries are either Muslim or Christian countries in Asia and Latin America, respectively, or francophone countries in Africa. In Sub-Saharan Africa, even where the laws or their enforcement is relatively liberal, the availability of services is so poor that most abortions continue to be clandestine (Coeytaux, 1988).

3. Sterilization.

3.20 Sterilization, one form of birth control that has come increasingly into practice during the last two or three decades (Ross, *et al.* 1986), is subject to legislation concerning

causing injury or bodily harm. Some relevant laws are of a general character (e.g. in Panama), others relate specifically to sterilization (Cuba) or contain regulations for physicians (Costa Rica).

Sterilization may be restricted by age and parity (Liberia). The examples are:

Panama, Act No. 18, Penal Code, 1982: "Art. 135. Whoever, without intending to kill, causes bodily or psychic harm to another... will be punished... Art. 137. If the injury produces incurable physical or psychic harm,... impotence or loss of the ability to procreate... the punishment will be... imprisonment." (Boland and Stepan, 1991, p. 324)

Cuba, Act No. 62, Penal Code, 1987: "Art. 273. Anyone who blocks, cuts off, or disables the procreative system of another will receive a prison sentence ranging from 5 to 12 years." (Boland and Stepan, 1991, p. 310)

Liberia, Act approving the National Policy on Population: "Section 7. (c) Sterilization shall be recognized as an effective means of fertility regulation... In providing sterilization, due consideration shall be given to the age of the couple or individual and the number of children." (Boland and Stepan, 1991, p. 266)

3.21 Legislation concerning sterilization has moved toward liberalization. Between 1973 and 1983 about 23 countries effected changes in their regulations favorable to sterilization. By the mid-eighties, laws in 23 countries explicitly permitted, in another 54 did not forbid sterilization and, among the latter, family planning programs of many large nations (e.g. China, India, Bangladesh, Pakistan, Korea and Thailand) actively promoted it. In 29 countries the situation is unclear, and in 29 other countries sterilization is forbidden, except for medical or eugenic reasons.

C. POLICIES CONCERNING HEALTH AND MORTALITY

3.22 Infant and child mortality, primary health care, maternal and child care, and family planning are all subjects of government health policies, and they are almost obligatory components of population programs, national development plans, and decrees concerning the health of the population. Surprisingly, however, with the exception of maternal health and family planning, the relevant policies and the debates surrounding those policies seem to suffer a kind of «gender-blindness». Infant mortality has long been regarded a sensitive indicator of general health conditions, and along with child mortality usually receives priority in health policies.⁷ Such indices, however, are rarely published or otherwise reported by sex. Notwithstanding the fact that under conditions of equal gender care the sex specific measures should reflect a genetically determined female advantage, health policies do not consider measures to redress the

distorted infant and
child mortality gender

balance.

Table 7. Governments' priority items for mortality policy;
United Nations Sixth Population Inquiry Among Governments

	Priority for mortality policy*	Major concern	Minor concern	Not a concern	No response provided
3.23 Health					
policies often reveal a	Vehicular accidents	59	33	6	10
preference for gender-	AIDS	54	28	16	10
less health programs,	Malnutrition	49	18	28	13
such as drives for im-	Measles	45	20	33	10
munization, campaigns	Whooping cough	33	23	41	11
to reduce infant and	Complications of abortion	30	31	34	13
	childbearing	43	32	18	15
	Other STDs	28	35	33	12

Source: United Nations, 1990a. * Selected priorities.

child mortality or against diarrhoeal diseases or malaria, but there are never campaigns designed to promote equal care for the girl child, which is badly needed in many developing countries. Indeed, as the United Nations Sixth Inquiry Among Governments shows, among 108 governments that answered questions about their mortality policy (three-quarters of them from developing regions), more governments had a major policy concern for measles than for complications of childbearing and more for whooping cough than for complications of abortion (see Table 7).

3.24 Two examples of health and/or population policies that pay specific attention to women's health needs in their childbearing years (but not before or after that) are manifest in the family planning programs and in maternal health care. During the 1980s, in most developing countries new family planning programs were established or old programs augmented, and the programs became more efficient (Mauldin and Ross, 1991). Although the purpose of family planning programs is usually not so much the improvement of women's health as the reducing fertility and infant mortality and, in Latin America, induced abortions, nevertheless, their impact on health is considerable. Concern for maternal health has recently become a priority that is recognized in the Safe Motherhood Initiative. Similarly important are the efforts of parliamentarians, who can provide the legal means to:

"Improve the status of women, particularly in areas of health, education and employment and create public awareness and acceptance of the changing role of women in Asia and of its social, political and cultural implications." (Asian Beijing Forum Declaration of the Asian Forum of Parliamentarians; quoted by Boland and Stepan, 1991, p. 246)

D. LEGISLATION CONCERNING GENDER EQUALITY IN SOCIETY

3.25 As with gender inequality in the family, inequality outside the family also has a deleterious effect on female health. The three main areas of legislation concerning equality of sexes in society that concern female health are political rights (equality before the law), education, and employment. Legislation in any of these fields may indirectly, in some cases even directly, affect female health. Gender equality in the society is a topic of several United Nations conventions and resolutions, such as the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Political Rights of Women, Equal Remuneration Convention (ILO No. 100), Discrimination (Employment and Occupation) Convention (ILO No. 111), General Assembly Resolution 43/101: Implementation of the Nairobi Forward-looking Strategies for the Advancement of Women, etc. (see, for example, United Nations, 1989a; United Nations Office at Vienna, 1988, 1990), and they are also incorporated in the laws of many nations.

3.26 Legal equality is necessary to empower women to make decisions in the interest of their own and their children's health. The importance of women's education for their health, and the care they may afford their daughters is obvious from every demographic analyses of the influence of female education on various socio-demographic phenomena. Indeed, "women's education can operate to influence the risk of death through several intermediate variables simultaneously." (Mosley, 1985, p. 127)

3.27 In the area of female employment, however, legislative concern in many countries go beyond the simple promulgation of equality of sexes in conditions of employment and remuneration or prohibiting discrimination based on sex. Such legislation takes into account partly the interest of socio-economic development (the inclusion of women into the labor force) and of the reproduction of the population, partly the special health requirements of the pregnant working women. The measures that are gender-unequal in the interest of the pregnant working woman and her offspring are usually:

- (a) paid maternity leave (pre-natal and post-natal leave),
- (b) provisions for child-care facilities, nursing breaks for the duration of breastfeeding,
- (c) leave to care for seriously ill child, and
- (d) exemption from work that is harmful to the pregnant woman, excusing pregnant women from work during the night, etc.

3.28 The enactment of such measures and the extent of the measures reflect the commitment of legislators to involve women in development, and to protect the child and the future of their nation.

IV. PROGRAM PRIORITIES AND OPTIONS

4.1 In culturally pluralistic societies such as are found in the great majority of developing countries, there are considerable differences in what female gender portends. And among countries, even where prevailing traditions are similar, there may be dissimilarities in manifestations of and adherence to those traditions. In nearly all of these cultures, partiality favoring boys is exhibited in some ways that are detrimental to girls' mental and physical health and well-being and that circumscribe their life options. And the manifestations of male dominance have the same consequences for women. Table 8 presents health-status profiles for females using three developing country models: Nepal/Bangladesh - poorest health and lowest social status; Egypt - moderate to low; Costa Rica/Jamaica - better health and more acceptable social status. In neither of these countries do the conditions in which girls and women live meet all desired standards, and needs for improvements are compelling. Among components of any plan to improve the lives of females in developing regions, those aimed directly to change the mores are the most susceptible to failure.

4.2 Within societies, there are individual differences in behavior, because people differ genetically, intellectually and in social, inter-personal and other experiences. But at all times, the frame of reference for the exercise of associated behavioral differences is culture, i.e., the material and non-material standards that determine the range of acceptable responses or behaviors in any setting and that dictate what is and is not allowable. Culture is most tenacious in closed populations and where social, economic and geographic conditions reduce or eliminate media

Table 8: Health status for three developing country types

Indicator	Country and level of indicator				
	Bangla- desh	Nepal	Egypt	Costa Rica	Jamaica
Minimum legal age of marriage (with consent)	18	16	16	15	16
Percent married by age 15	73	36	11	4 ¹	13 ¹
Median age at marriage younger than legal age	Y	Y	N	N	N
Level of fertility (TFR) ²	5.53	5.94	4.53	3.28	2.65
Maternal mortality, 1985-90 ³	580	800	316	27	76
Son preference index ⁴	3.3	4.0	1.5	1.0	0.7
Ratio of male to female child mortality	111	105	87	83	70
Gender equity in access to food and nutrients	N	N	N	...	N
Gender equity in access to good medical care	N	N	N	...	Y
Female per 100 males in secondary school, 1985-90	39	30	65	104	105
Domestic violence reported	Y	Y	Y	...	Y
Currently married women using modern contraceptives (%)	22	13	35	58	51
Percent births with trained attendants	5	6	47	93	89
Percent pregnant women immunised against tetanus	11	31	88	90	50
Abortion on demand	N	N	N	N	N
Abortion on ground of woman's health	N	Y	Y	Y	Y
Females per 100 males in sales, clerical and service work	29	...	23	95	182
Percent females aged 15+ economically active, 1990	7	43	9	84	68
Convention on women ratified as of 1990 ⁵	Y	N	Y	Y	Y

Notes:

¹ In 1983, 76.1 percent of Jamaican and 36.1 of Costan Rican girls aged 15-19 years were living in a consensual or visiting union.

² Number of births per woman of completed fertility given the fertility schedule for the years, 1985-90.

³ Maternal deaths per 100,000 live births.

⁴ The ratio of mothers preferring the next child to be a male to those preferring a girl. For example, in Nepal, boys were preferred over girls four to one.

⁵ Convention of Elimination of All Forms of Discrimination Against Women signed and ratified as of 31 December 1989.

Sources: Acsadi and Johnson-Acsadi, 1990; Henshaw, 1990; PAHO, 1990; Ravindran, 1986; UNICEF, 1991; United Nations, 1987, 1989, 1991 and files of the Population Division; United Nations Office at Vienna, 1989a; Weinberger, 1991; Zahr and Royston, 1991.

influence, but it is not unalterable. The introduction of new technologies, however simple, alters ways of doing things, and advances in education widen receptivity to new ideas. The challenge is to identify those problem areas that are most readily susceptible to change and to formulate programs and policies that will successfully exploit them, thereby cultivating an environment conducive to overall gains in the better health and well being of all females. The following

priorities, which may be adapted as conditions demand, are accompanied by information on relevant program experiences wherever possible.

1. Provision of Better and More Information on Girls and Women.

4.3 The understanding of a phenomenon is a prerequisite for changing it. Thus, it is essential to have more reliable information on differences between males and females in health status, nutrition, mortality and socio-economic attributes at critical life stages and for data that enable comparisons between females who experience specific debilitating discrimination and those who do not. But such data are in short supply. Hence, it is important that both governmental and inter-governmental agencies increase the supply of reliable, relevant statistics for both sexes at all ages.

4.4 Researchers must be more sensitive to the importance of avoiding gender bias. Further, it is their responsibility to reflect in their work gender differences in cultural, social, demographic and economic phenomena as well as legal status and rights, so as to facilitate the development and implementation of strategies and programs aimed to eradicate gender discrimination. Propitious results might be achieved by the sponsorship or support of round-table symposia at national and international meetings of scholars in relevant disciplines. Other appropriate targets might be public health officials, population census planners, survey researchers, registrars general and others who supply or collect data for relevant research, planning and program implementation. Poor vital statistics registration and lack of proof of age

are among the reasons that have been advanced for governments' failure to enforce laws governing age of women at first marriage (UNFPA, 1992).

2. **Greater Awareness Among Governments Officials of the Need to Protect Females from Violence**

4.5 Appropriately designed international surveys could be carried out to ascertain the amount and kind of violence perpetrated against females and to determine the legal recourse available to girls and women and its likely effect with the view to inviting appropriate government action. However, even where laws protecting women against violence exist, they are often ineffective.

3. **Compliance with Laws Affecting Women's Rights Is Essential**

4.6 Laws and traditions in many countries are at variance with the provisions of Article 1 of the *1979 Convention on the Elimination of All Forms of Discrimination Against Women* and other international instruments. On the other hand, there are laws and policies now in effect in many countries that would have a salutary effect upon the health and lives of females were they enforced. But enforcement is often lackadaisical and indifferent or difficult to accomplish. This is particularly so where legal age of girls at first marriage is concerned. Among 38 developing countries that participated in the World Fertility Survey, for example there were six in which 25 percent or more of women (aged 20-24) married or entered into marital union by age 15 prior to the legal permissible age. In Bangladesh, Nigeria, Mauritania, Nepal, and Yemen, the proportions married or living in union by age 15 were 78, 40, 39, 36, and 35 percent, respectively (United Nations, 1987). In another example, female circumcision was

banned in Sudan in 1946 and in Egypt by decree in 1959 and by law in 1978. However, there was resistance, and the practice continued surreptitiously (United Nations, 1986).

4.7 There is a need for pilot studies of ways of exploding rationales for various practices that are harmful to females and of means dealing with the practices that do not respond to legal remedy.

4. Mobilization of Political Will to Modify Tradition

4.8 One approach would be to organize at grass roots level community leaders, men and influential women to address government on issues of women's rights and needs, with emphasis upon advocacy for the passage of necessary legislation, and enforcement of existing laws governing age of females at marriage and requirements as to their school attendance. It may prove imperative first to educate the populace itself as to the rights and needs of females as well as to the power inherent in grass roots demands.

4.9 The enlistment of community participation to change official policy and public opinion about the rights of females offers promise, particularly in societies that have allowed the broad scale breach of these rights with seeming impunity. The Asian and Pacific Women's Resource Collection Network (APWRCN, 1990) lists 10 categories of violence commonly perpetrated against girl children and women of all ages in various countries of that region. Laws and ordinances may punish the victims, as in the case of rape⁸, rather than protect them. In some places, the principal sources of change appear to have been women's community action groups, as in the following three examples.

4.10 Five Malaysian organizations joined in 1984 to create a Joint Action Group Against Violence Against Women. The Group enlisted support of the media and the police (which formed a special police squad of women personnel trained to deal sympathetically with raped women) and campaigned for heavier punishment for offenders with the result that the incidence of such crimes noticeably decreased (APWRCN, 1990).

4.11 Women's organizations in Bangladesh campaigned successfully to achieve passage of the Prohibition of Dowry Act in 1980, illegalizing a practice long responsible for wife murder (APWRCN, 1990).

4.12 Vigilante action on the part of local women in a village of Maharashtra State, India has been more effective in curtailing men's violent acts against women than government efforts, because the women banded together and exposed the offending men to public ridicule (Stinson, 1986).

5. Elimination of Girls' and Women's Disadvantages in the Allotment of Food and Food Supplements

4.13 Government officials, local authorities and health workers, among others, must be made aware of the adverse effect that such gender discrimination has on individual women, as well as their children and the society, and of the necessity of abolishing it.

4.14 There are in many developing countries programs that provide food and/or nutrition supplements, and these programs offer considerable potential for the improvement of health among females. The American Public Health Association is reported to have surveyed 180 health projects in developing countries in 1977. The interventions included food and nutritional supplements, nutritional fortification of commonly consumed foods, home gardening and nutrition education (along with care for parasitic infection and family planning). Among the 27 projects directed to women, impediments to the desired outcome included the influence of food taboos, family food distribution patterns and actual food scarcity (APWRCN, 1990; Stinson, 1986).

4.15 The Narangwal Study (conducted in 26 rural villages of Punjab, India) demonstrated that the success of health interventions may require disdainful treatment of established cultural patterns. When parents neglected to take their weight deficient children to the center for food, workers visited the homes and supervised the children's feeding, overriding the family food allocation system to the advantage of girl children. In the health care component of the study, no such follow-up was initiated, and parents were more diligent in taking sons than daughters for health care. Actual decreases in mortality rates attributable to the health care interventions were 0 for male children and - 4.4 per thousand for females. The nutrition intervention effected mortality rate decreases of 3.1 for boys and 10.9 for females (Pebley and Amin, 1991).

4.16 For several reasons, examples of good food and nutrition programs for women are scarce. Either reports on food/nutrition programs do not specify gender, the projects may not aim to influence gender differences in nutrition or they may not be evaluated from that perspective. More is known of food/nutrition programs for pregnant and lactating women. On-site programs aimed to supplement maternal dietary intake are said to be more effective than take-home programs, because the woman is not required to share with family members. However, in an Indian food program, this problem was reduced because workers made frequent home visits and monitored diets (Stinson, 1986). Some programs have distributed food for the whole family with the desired result, as in Morocco, while this procedure netted Colombian women only a fraction of their share (Stinson, 1986).

4.17 Most population nutrition programs in developing countries are aimed to help children alone. Even those addressed to women are more often intended to protect the health of unborn or nursing children, and there appears to be little food/nutrition assistance to women outside the context of motherhood. Furthermore, the effects of the programs are ordinarily assessed in terms of their impact on pregnancy outcomes and children's early development (APWRCN, 1990; Stinson, 1986; UNICEF and Sierra Leone, 1989; UNICEF and Indonesia, 1989). While such programs are indispensable, lack of similar agendas for women leaves many women vulnerable to malnutrition and its effects.

4.18 Isolated interventions may be less successful than nutrition programs that are a part of a larger initiative or combined with a supportive one. Reportedly, there was marked

improvement in the diets of Indian women participants in a program that provided food and food supplements combined with the study of diet and nutrition, medical care and the development of literacy skills. But a program for Philippines women that consisted solely of weekly home economics classes for one year did not yield such results (Stinson, 1986). Short-term, small scale interventions to improve the nutrition of pregnant and lactating women in Sierra Leone are held to have been of little benefit (UNICEF and Sierra Leone, 1989). Further, little positive results can be expected of nutrition education programs unless they are directed to those family members, such as husbands and mothers-in-law, who ordinarily allocate family food (Satia and Jejeebhoy, 1990).

6. Implementation of Health Interventions for All Females with Due Consideration for Cultural Issues and Barriers

- 4.19 Where women are secluded or cannot travel without a male escort, health services should provide periodic home visits by trained female health workers (doctors, nurses or paramedics). A shortage of qualified female workers and inadequate systems of worker supervision limit the effectiveness of such a program, however, particularly in remote rural areas.
- 4.20 Male-female health teams may be used, *inter alia*, where the safety of women health workers, treatment of females by women only and husband consent are at issue. Male general health workers have been paired with female traditional birth attendants in Afghanistan, Senegal and other countries. In Oman, rural development teams consisted of three males to deal with agriculture and sanitation and a female maternal and health assistant to provide maternity services. Husband-wife teams have also been used, as in an area of Egypt, where male health

workers taught their wives to give injections and change dressings. In the Guatemala Family Planning Association, family teams were found to be 30 percent more effective than persons working alone (Stinson, 1986).

4.21 Maternal health care for all who need it is indispensable, including health facilities (clinics, home care health workers, mobile health units) that can meet the needs of adolescents. And health care is required for all other females without reference to motherhood (APWRCN, 1990; Stinson, 1986) and for unmarried as well as married women. Failure to cater to these needs is to ignore causes of female mortality and morbidity that are unrelated to childbearing and that afflict women of all ages.

4.22 It is important that health care facilities be established, staffed and operated with regard for women's overall needs. Clinics have been set up for women in rural Java, for example, but attendance is poor. In Nagaklik, the facilities are built along western lines with bench rather than floor seating to which the women are accustomed. The clients' speech patterns and dress mark them as socially inferior to the care givers, and services are free only to those bearing a stigmatic letter from the village administrator stating their inability to pay. Inconvenient clinic hours and long waits added to the unattractiveness of this health project (APWRCN, 1990).

4.23 Good health practices may be introduced or furthered through cost free, conveniently located and well publicized seminars and workshops, as in the following example.

4.24 The Woman Health Movement Philippines conducted a two-day health workshop in Manila at which education in anatomy, contraceptives and issues relating to pregnancy preceded the clinic services. The latter included pap smears, pelvic examinations and general check-ups. Offered in the framework of a "sisterhood" experience, the women, some of whom had travelled great distances to attend, clamored for similar health programs in their own communities (APWRCN, 1990). In eastern Nigeria, too, local women's groups joined to form a Safe Motherhood Network aimed at developing and implementing health education and training programs (Otsea, 1992).

4.25 In some settings, elements of home self care might be successfully promoted. Many women in remote rural areas could be taught to use a thermometer, for example, and to detect certain signs of malnutrition, among other health measures. Longhus Commune in China developed a home care system which, though prenatal, might serve as a general model. Health professionals went into homes to teach pregnant women and their husbands how to monitor pregnancy, including development of the fetus, to detect evidence of the woman's own health problems, and to determine when recourse to medical care was indicated. An MCH hospital provided for each pregnant woman without cost a stethoscope, test-tube, medicine and a special chart. Significant declines in prenatal and postnatal maternal mortality and complication rates and improvements in fetal health are attributed to the project (Shen, 1985).

4.26 Both medical and nutrition interventions are needed to ensure healthier pregnancy and safer childbearing. Schemes vary widely, as in Nigeria and Nepal.

- 4.27 Prenatal care for girls aged 15 and under in Zaria, Nigeria, included iron and folic acid supplements and malaria chemoprophylaxis to counteract anemia but, owing to the consequent added height of 2-16 cm after 20 weeks, an important by-product was a dramatic reduction in the incidence of cephalopelvic disproportion and obstructed labor (Rooney, 1992; Harrison, 1990).
- 4.28 A National Nutritional Support Programme had been introduced in Nepal with WHO and UNICEF support to combat protein/calorie malnutrition and micro-nutrient diseases. Supplements of iron and vitamin A are aimed, *inter alia*, to reduce maternal malnutrition and anemia. A companion program promotes functional literacy and educates women in child care, Oral Rehydration Therapy (ORT), health and nutrition as well as prenatal and postnatal care. One expected outcome is lower maternal mortality (UNFPA, 1989).
- 4.29 There should be careful assessment of the potential effectiveness of TBAs in improving maternal health. Maine, *et al.* (1986) present evidence of the need for more extensive TBA training and close supervision of their effectiveness. These authors note that the result might be of value where next level referral is instantly available, as in Fortaleza, Brazil. But Harrison (1990, p. 10) states that no "system of traditional medicine [including TBAs] is known to reduce maternal mortality." He denies the usefulness of TBAs in any case, as does Ofosu-Amaah (1991), and Mhloyi (1990) questions it.

7. Prenatal Screening

4.30 Prenatal screening should be a part of programs of prenatal care. Women judged to be at high risk of complications should be identified and referred for timely medical treatment and appropriate assistance at confinement. Scholars (e.g., Maine, *et al.*, 1987) have shown, however, that there are drawbacks to reliance upon screening. Not all high risk women obtain prenatal care, and many are thus not screened. Too, some major problems, such as hemorrhaging, cannot be foreseen. Further, because predictions of probable labor complications are not infallible, many screened women receive unnecessary treatment as high risk and at considerable cost. On the other hand, there is said to be scope for the risk approach when it is effectively implemented and bolstered with an adequate referral system. Without such support, screening programs do not yield the desired results (Rooney, 1992; Maine *et al.*, 1986). Homes at which women with expected complications await delivery are examples of good support systems. Waiting places in Nicaragua, Nigeria and Cuba are described below.

4.31 Casa Materna in Northern Nicaragua operates two separate centers for women who reside in rural and periurban areas: The Centre for High Risk Pregnancies and The Continuing Education Centre. The latter offers local women a six-week course about childbearing, breast feeding and family planning. The Centre for High Risk Pregnancies offers cost free assistance to rural parturient women who have been diagnosed as being at high risk. The women enter one week prior to their due date. While awaiting delivery, they assist with the housekeeping chores and in the income producing activities, and, when labor commences, they are walked approxi-

mately twenty blocks to the hospital. Of the 216 women cared for since 1988, none has died of a childbirth related illness (Wessel, 1990).⁹

4.32 At the "maternity village" near Uyo in eastern Nigeria, women at risk may be accommodated for the last trimester of their pregnancy. Under medical supervision, they receive iron and vitamins and antimalarial drugs and are instructed about child care and nutrition. As a consequence, maternal mortality at the attached Ituk Mbang hospital is said to have dropped from 10 per 1000 deliveries to 1 per 1000 and the stillbirth rate from 116 to 20 per 1000 deliveries (Royston and Armstrong, 1989).

4.33 The establishment of maternity homes at which women from outlying districts may be accommodated during the last two weeks of pregnancy is said to have made a marked contribution to the 75 percent decline of maternal mortality in Cuba over the past three decades (Cardosa, 1986). It should be noted, however, that all pregnant Cuban women receive cost free antenatal care by graduate obstetric nurses, a factor that must necessarily have aided in lowering maternal mortality. Even where maternity waiting homes or similar facilities are available, many of the women most in need of the service will not benefit from it so long as attendance is contingent upon antenatal care and risk screening.

4.34 There is a need for schemes that ensure prenatal care and adequate referral for those pregnant women who lack cognizance of the efficacy of such care or who, for whatever reason, are unable to obtain it. Home visits to all indigent families is one approach. The

Maternity and Child Welfare Association of Pakistan (MCWAP) has developed such a program for poor women in Lahore. Through house to house visits by health personnel, families, children and women of childbearing age were registered. Such records were kept as would allow the identification and monitoring of all pregnant women, who are given nutritional supplements, examinations and treatment. They are taught about child care, contraception and the process of childbearing. Complicated cases are referred to clinic doctors (*Safe Motherhood*, 1992).

4.35 Linked referral systems are needed for rural areas and villages that do not have health clinics or trained personnel. A maternal health scheme in southern Ethiopia utilizes messengers who, when there is a difficult labor, alert first a TBA and then, immediately thereafter, the sisters at a primary health care post who assist the woman's transferral to the health service's first referral level. A similar program was operated in a rural Nigerian community during the mid-1970s (Royston and Armstrong, 1989). When telephone service or another means of rapid communication is available, effective maternal health schemes can be more easily instituted. Emergency equipment, ambulances and modern practitioners may be summoned expeditiously in cases of obstructed labor, hemorrhage or other complications, as demonstrated by the "obstetric flying squad" system (Royston and Armstrong, 1989). But efficiency in such a system presupposes that women will be attended by someone knowledgeable as to when referral is necessary.

8. Sensitization of Men to the Plight of Women, to Their Rights and to the Maleffects of Maternal Illness and Death Upon the Family

4.36 It is important that men be given information that will foster change in their perspective about women and girls as human beings. Wherever practicable, programs aimed to change the position of women and to ameliorate their social and physical burdens should obtain men's support. They should be enabled to participate in the planning and implementation of health and nutrition programs for women once their cognizance and acceptance of the problems and needs for change is evident. In most societies in these regions, political authority rest almost solely with men. Thus, projects to improve the health of females should include strategies to gain and hold men's attention and motivate them to empathetic action. Evidence of the efficiency of this course may be found in a number of health, nutrition and family planning programs. Three examples follow.

4.37 The Nigerian Institute of Child Health organized Fathers' Clubs to accommodate the fact that, in that country, men make most decisions regarding family health. The club members now promote immunization, good nutrition and child growth monitoring and encourage their wives to do the same (Stinson, 1986).

4.38 The National Family Planning Board of Jamaica developed a program to counteract widespread antipathetic male attitudes toward family planning. Men were attracted to the program through wide media advertising, dramas, radio programs and other means that carried messages about male responsibility in family planning. The response is reported to have been gratifying, with many men now serving as motivators. Relatively fewer women experience

partner resistance to contraceptive use, and more men are users (Stinson, 1986; Weinberger, 1991).

4.39 Surveys in Zimbabwe revealed that men, who make the decisions about family planning use, were the chief source of resistance to it. A great many women users were doing so surreptitiously and at great risk. The Zimbabwe National Family Planning Council ceased its one-sided focus on women and developed a program to increase men's knowledge and understanding of contraception and its value and to gain their active participation. Carefully chosen male leaders held workshops, seminars and informal discussion for men, and messages - including the effect of family planning on women and children's health - were tailored specifically to men. A radio program on family planning attracted a wide audience. A follow-up survey disclosed that, as a result of listening to a single radio program, a drama, men said that they had discussed contraception with wives, girl friends and/or medical personnel. Over 60 percent reported a change in attitude, and 30 percent had used contraception (IPPF, 1992).

4.40 Government authorities, community leaders and family heads should be apprised as to the health consequences for girls and women of the heavy work burdens that they endure, and the importance of using animals and labor saving devices wherever possible.

9. **Enhancement of Knowledge of, Access to and Utilization of Contraceptives**

4.41 It is essential that all legal and logistical restrictions to the use of all medically approved methods of family planning be eliminated. There are many places where there is no

official opposition to family planning, but also little or no effort to make knowledge and means of family planning available. The Amsterdam Declaration called upon all countries to "ensure that all couples and individuals are guaranteed the basic human right to decide freely and responsibly the number and spacing of their children" (UNFPA, 1989, p.9).

4.42 Active community involvement in the planning, design, implementation and quality evaluation of family planning programs should be promoted (UNFPA, 1989), so as to facilitate dialogues on the efficacy of family planning and to create and sustain wide acceptance and use of contraceptives. All community leaders, socially prominent persons, interest groups, representatives of those requiring service and the media and other forms of communications should be involved.

4.43 Family planning programs must meet the needs of adolescents. Some programs have accommodated young people by offering them special programs and services as in the following examples. Family Planning Associations in Mexico, Guatemala, Costa Rica and other Central American countries train adolescent counselors to promote family planning among their peers. Multi-service youth centers offer family planning information and service along with job-related and recreational activities (Harper, nd). The Hong Kong Family Planning Association counsels adolescents in a building that is located some distance from its regular quarters where adults are served. The facilities are modern and very attractive with youth oriented music. The receptionist is young and empathetic. Interviews and service are private. In the Republic of Korea, too, special facilities are operated to serve adolescents. A hotline operator is a well

trained young person supported by trained adult backup. Service is combined with a wide variety of youth activities and, as in Hong Kong, these services are widely publicized and used, and they have had a depressing effect upon teenage childbearing.

4.44 There is a need in many places for programs and facilities that will satisfy the requirements of unmarried women and men for contraceptive advice and service in culturally acceptable circumstances. Programs for men, for example, have been centered at work places, at labor union quarters, and even coffee houses where these are popular with men, as in some Muslim countries. In a number of places, male motivators have been used successfully (IPPF, 1992). Where society exacts a penalty for extra marital coitus, unmarried women will not go to family planning clinics. However, they might be enabled to obtain contraceptive advice and service privately at general health clinics and in hospitals.

4.45 It may be required to devise techniques to break the grip of tradition upon human behavior if women are to receive the full health benefits of easily accessible family planning knowledge and means. Culture and social institutions act as especially compelling and tenacious restraints. Efforts might be made, for example, to alter perceptions about status giving attributes. To remove the halo that, in numerous places, having many children and/or sons confers, one course might be to develop and gain public support for alternative means of acquiring status that are achievable by the average woman and man.

10. Prevention of AIDS

4.46 Beginning with the earliest school grades that culture will allow, children should be taught about AIDS. And there should be created a national dialogue on its sources (including certain codes of sexual practice) and symptoms and its disrespect for those exposed to it, as well as measures for protection against the disease. Such programs should also inform about other sexually transmitted diseases. UNICEF (1990) has supported a number of programs aimed to make young people aware of AIDS and to prevent its spread. In Uganda, the science curricula for primary and secondary schools have been completely revised to include health education and AIDS prevention. New text books, class materials and extra-curricular activities have been developed. Priority is being given to similar programs in Burundi, Rwanda and Thailand. Workshops for women, leaders, teachers and the mass media are a part of Tanzania's drive against AIDS. In Uganda, health workers, educators, church congregations, women's groups and village committees have been targeted for information about AIDS and other STDs and are agents in the drive against these diseases. Broad educational programs that involve whole villages would have an impact. Health workers might also visit homes so that women and their husbands or partners could receive the information together, and each would be told how protection against the disease is accomplished.

11. Empowerment of Women

4.47 Women must be enabled to act independently on their own behalf where their health and well being are concerned. Their inability to do so is a corollary of the cultural tenets and societal interdictions that govern their lives. But even where means are devised to circumvent

the effects of these constraints (e.g. establishment of community and gender support groups for women), illiteracy, lack of educational opportunity, heavy work burdens, restrictive laws and/or lack of legal redress combine with other factors to deprive women of the knowledge, will and means aptly to care for their health. Eradication of illiteracy, better education, and own income are among the conditions that will help women to manage their health better.

4.48 The persistent gender gaps in secondary school enrolment must be eliminated and girls assured the same access to all levels of schooling as boys. A number of countries have instituted programs to this end, including Bangladesh, India, and Jamaica, as described below.

4.49 In villages, especially, Indian parents will not send their daughters to male teachers. Thus, in its Seventh Five Year Plan, the Government of India is giving priority to the training of female teachers. The plan also provides special incentives (uniforms, books and scholarships) for the schooling of needy girls (UNFPA, 1990a). In rural areas of Bangladesh, girls' education is now cost free up to the eighth grade, and all new primary-level teaching recruits will be female (UNICEF, 1991, 1991a). Many Pakistani girls who do not have access to formal schools are educated in Home Schools (UNICEF, 1992).

4.50 In Jamaica, a program for adolescent mothers and expectant mothers provides schooling in academic subjects and training in marketable skills, along with health and family life education classes. One effect of the program has been a change in official education policy,

so that pregnant girls are now permitted to remain in school and adolescent mothers may return to school after their children are born (UNICEF, 1991).

4.51 The Bangladesh Rural Advancement Committee (BRAC) developed a non-formal primary education program in 1984 that offers schooling in two and three hour sessions and allows for children's daily and seasonal work. It uses community para-educators, 75 percent of whom are women, and has 90,000 students of which 70 percent are girls. After three years in the system, students may enroll in grade four of the formal school system (UNFPA, 1990b).

4.52 It is essential that girls and women receive their fair share of education and travel scholarships, financial loans and grants receivable by governments as international technical assistance. Opportunities in this sphere should improve as growing numbers of women annually reach the educational levels at which such support may be needed. Owing to the gender pattern of government submissions of requests for training fellowships, only 944 or 19.9 percent of the 4,739 training fellowships awarded by the United Nations Development Programme in 1991 were to females. In 1990 and 1989, the percentages were, respectively, 20.1 and 25.0 (United Nations, 1990b, 1991d, 1992e). Governments should be encouraged to alter this pattern, among other ways, by urging more females to apply for these fellowships.

4.53 Development schemes should include provision for such structural readjustments as will enable women to earn a livelihood in the formal rather than the informal sector, where financial remuneration tends to be poor, and work is often undertaken in unsafe and insanitary

conditions (United Nations, 1989b). For example, in a number of developing countries, agricultural restructuring has meant the shift from mainly cash crops normally produced by women to export crops (United Nations, 1991a) with which they are less involved. Such changes might be accompanied by projects to include women, especially household heads, in the formal sector thereby minimizing the effect of their economic losses.

4.54 Where women do not have free entitlement to the money that they earn, laws are needed that would guarantee them access to and use of the money that they earned.

12. Some Critical Impediments To Achievement of Goals in Health and Nutrition Programs

4.56 The materials reviewed for this study revealed, often inadvertently, factors that constrain to inhibit or diminish the effect of efforts to improve the health and nutrition of females and/or that prevent the institutionalization of successful projects. Some of these are indicated in the following.

4.56 Insufficient attention is given to quality evaluation of programs and to program impact (see, e.g. PAHO, 1990; Singh, 1989; UNFPA, 1990b). Both program administrators and funding agencies have an interest in evaluating program performance. When the government evaluated a health project in Punjab, it was found that the program did not operate as intended, that some staff lacked integrity and that the lower classes, for whom the program was implemented, did not avail themselves of it (Singh, 1989).

4.57 Supervision at each level of program implementation is often lacking. Evaluation would disclose the need for it. An MCH program for five villages in Uttar Pradesh, India, provided that an ANM (registered nurse) should visit each home to provide maternal and child care. The ANM assigned to Krishanpur "hardly" visited the village, refused to see cases at night and charged fees for deliveries that were beyond average family means. The MCH center in the village was more often closed, and the ANM is reported to have neglected her duties with impunity (Kahn, *et al.*, 1989).

4.58 Women themselves often represent a nearly intractable problem. As the bearers of culture, women perpetuate discrimination against girls. It is they who perform circumcisions and insist upon the early marriage of their daughters. Women discriminate in the distribution of food and, as mothers-in-law, dictate the living conditions of young brides, assign their chores and determine when they may have health care (UNICEF, 1990; Kahn, *et al.*, 1989; United Nations, 1986; Singh, *et al.*, 1962).

4.59 Effectiveness of programs is diminished when they are designed and implemented without due regard for culture (UNFPA, 1990; Stinson, 1986).

4.60 Waste, conflict and lost opportunities for effective program results occur when the various national, local and external agencies working within a country in the same or similar population and health fields do not collaborate and when agencies do not have the full and expeditious support of government and local authorities (Johnson-Acsadi and Taylor-Thomas,

1989). NGOs and other external agencies often do not share or share fully information on program procedures and work from the top down, inhibiting institutionalization. Also, the cost of externally funded programs is frequently beyond government means. In these circumstances, replication and sustainability of projects is more often not possible (UNFPA, 1990a, 1990b; Johnson-Acsadi and Taylor-Thomas, 1989).

4.61 External assistance aimed to improve the health and nutrition of women and girls might yield greater benefit if donors were to find ways of cooperating with governments to ensure the equitable distribution of and access to the food and food supplements and health care equipment and services that they provide.

NOTES

¹ The Demographic and Health Surveys found less strength of son preference in 26 countries and little manifestation of it in the feeding and health care of children (Arnold, 1991). However, the World Fertility Survey results support the findings of strong son preference reported in many small area studies (Ravindran, 1986; Das Gupta, 1987; United Nations, 1986). Further, research and testimonials by scholars native to the regions where the practice is common strongly proclaim its pervasiveness and maleficent nature.

² Patriarchy assumes many forms, and its ability to impose a man's will and authority is far reaching. Male attitudes about family and male authority and prerogatives about sex influence contraceptive use. Where men oppose family planning, the effect can be its complete sabotage. On South Asia, see United Nations, 1973; UNICEF, 1990; Bhatia, 1982; for South and Central America, see Stycos, 1968, 1981; Shedlin and Hollerbach, 1981; IAPG, n.d.; Tucker, 1986; PAHO, 1983; for Sub-Saharan Africa, see Carlos and Diallo, 1986; Luhanga, 1992; United Nations Office at Vienna and CEPED, 1992; UNICEF and Nigeria, 1990; Shepherd, 1989; for Western Asia and North Africa, see United Nations, 1973; Chamie, 1981; Obermeyer, 1992.

³ This has been observed in other Muslim societies as, for example, in the Sahel countries of Central Africa where the perception of women as being only procreators and nurturers coincides with low prevalence of contraceptive use (Boyçe, *et al.*, 1991; Posner and Mbodyi, 1989). Chamie (1981) found this cultural norm to be prevalent, but fading in Lebanon.

⁴ It was seen in chapter I that one effect of increased education of mothers can be a widening of the gender difference in children's food allocation and nutrition status favorable to boys. It will also be recalled that better education of women should not be equated with female autonomy. It is the latter that enables women to act independently of the views and demands of others and to abrogate custom.

⁵ Several examples may be cited. In its annual reports, *State of the World's Children*, the UNICEF table number 7, "Women", gives three health measures: pregnant women immunized against tetanus; births attended by trained personnel; and maternal mortality rate. PAHO's otherwise excellent review, *Women in Health and Development* (PAHO, 1983), attempts but fails to avoid this trap, and none of the eight UNICEF Situational Analysis reports examined discussed women's health outside the context of childbearing, though they purported to examine the lives of women (not mothers) and children (see, e.g., UNICEF and Indonesia, 1989). PAHO (1985, p. 84) records that "This condition [malnutrition] has extremely important consequences for women since it affects their reproductive function to a significant degree". And in a 64 page report on *Living Conditions in Developing Countries in the Mid-1980s*, a Supplement to the 1985 *Report on the World Social Situation*, the United Nations (1986a) devotes two brief paragraphs to women. One deals exclusively with childbearing and the other with effects of food allocations on girls and pregnant and lactating women. Sex differences in literacy are allotted half a paragraph.

⁶ Table 6 is a somewhat simplified review of the situation concerning induced abortions. In federated countries, as for example in Mexico, the table shows the exceptions in the Criminal Code of the Federal District that apply to all offenses within the jurisdiction of the Federal Courts (the exceptions are: rape, pregnancy that endangers life and abortion that results from failure of the woman to take proper care). But some of the Mexican state criminal codes range from the more restrictive to the more permissive. In eight states the criminal codes are nearly identical to those of the Federal District but, Guanajuato and Querétaro authorize abortion only in case of rape. Hidalgo and San Luis Potosí added health reasons to rape. In addition to the federal exemptions, the health reasons are also recognized in Michoacán, Tlaxcala, and Zacatecas, while the Social Welfare Code of Yucatán accepted economic reasons. Several states also recognized eugenic reasons (Boland and Stepan, 1991). In many countries, where abortion may be punishable under law, there are not only narrowly or broadly stated exceptions, but the courts may also demand factual evidence that abortion occurred. Further, the enforcement of such laws may be very weak, as is the case in many developing countries.

⁷ An indication of the tendency of health planners to be concerned more with the mortality of infants than with other population groups is provided by the answers to the United Nations Sixth Population Inquiry Among Governments. Infant mortality is a main component of expectancy of life at birth. Among 108 governments, however, only 53 hold the view that the current life expectancy is not acceptable but 70 expressed the opinion that the level of the current infant mortality is unacceptable.

⁸ The Haddod Ordinance was put into effect in 1979. It requires that a rape victim prove her charge. To do so, she must produce four Muslim male eye witnesses of impeccable character. When this is not done - a near impossibility, and if sexual penetration is proved by medical reports or by pregnancy, the woman is charged with committing the act of sexual intercourse outside of marriage (APWRCN, 1990, p. 188).

⁹ Casa Materna receives financial support from the Government of Sweden, Canadian Save the Children and the Maryknoll religious order. Its quarters are supplied by the Government of Nicaragua. Workers volunteer their services (Wessel, 1990).

¹⁰ Gwendolyn Johnson-Acsádi visited the Hong Kong Family Planning Programme and the Planned Parenthood Federation of Korea in an official capacity in 1986. An essential feature of each was observed to be the special services for young adults.

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